MENTAL HEALTH

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EDITOR: R. F. TREDGOLD, M.D., D.P.M.

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Editorial

INSTITUTIONS FOR DEFECTIVES

The problem of providing institutional care for mental defectives becomes steadily more important for the health of society and everyone should consider its implications. The responsibility for ascertaining a defective in the community, is of course, that of the local health authority; for finding beds the regional hospital board is responsible. Inquiry of the latter shows that most heartrending appeals from desperate parents are constantly being received, and that pressure is daily being exerted on those responsible for allocating the existing beds. But the answer can only be that there is already an enormous waiting list and that no hope of a definite date of admission can be given.

The tragic results which may follow on the presence of a low-grade defective in a home are obvious enough, and sympathy for the unfortunate parents is readily forthcoming from their friends, general practitioners and neighbours. The mental strain on the mother, the interference to the father's work, the harm to other children and the effect on family life lived in close quarters are also easy to imagine. They provoke frequent questions and appeals to members of parliament, and ministers. But the making of appeals, and the offering of sympathy in response to them, are not enough.

The introduction of the National Health Service did not of course produce any more beds or any more nurses for the work. Nor can it have produced more defectives, though there is some evidence to show that there has been an increase in the number ascertained—due perhaps to the tendency to overuse anything new and to the idea prevalent in some quarters that all one's burdens can now be cast on the National Health Scheme.

It seems on inquiry that the position in the various Regional Hospital Boards varies but that the numbers of defectives on their waiting-lists ranges from 200 to 500 which probably gives a rough total of some 5,000. A high proportion of these are young children. Plans have, of course, been already made in most regions for more accommodation and for a greater establishment of medical and nursing staff. Unfortunately these plans cannot be put into effect without a very considerable amount of expenditure and without a very considerable increase of nurses for this work.

In the long run, therefore, the problem is twofold. It is that of those who control the treasury who must decide whether the care of defectives is more urgent than, say, the care of the tuberculous, the provision of new operating theatres or the supply of false teeth. Secondly, it is that of the community which is faced with the choice either of nursing its defectives at home or of supplying a large enough body of its sons and daughters to train for the work of caring for them in institutions.

The idiot, in earlier times alternately despised as an outcast or venerated, now is seen as an integral part of the human race in its struggle for evolution and survival, unwittingly yielding information of the greatest value in the progressive understanding of the biological structure of the whole group. High-grade and borderline mental defect are phenomena which have come into prominence only since human life has become urbanized and industrialized. Civilized communities must learn to tolerate, to absorb and to employ the scholastically retarded and to pay more attention to their welfare. Subcultural mentality must inevitably result from normal genetical variation and the genes carried by the fertile scholastically retarded may be just as valuable to the human race, in the long run, as those carried by people of high intellectual capacity.

L. S. PENROSE, *The Biology of Mental Defect*.

Morale and Mental Health in Modern Society

By R. F. TREDGOLD, M.A., M.D., D.P.M.

Paper read at the Annual General Meeting of the National Association for Mental Health, January 6th, 1950.

I feel that the title chosen by your Council for this Annual Address is one which is particularly important to us all at the moment, and particularly appropriate for this Association to discuss. We had hoped to have Sir George Schuster to speak ; but most unfortunately he had to refuse, and as I had gone a little way to put before my fellow members of the Council the importance of the subject, I was in a very awkward position when they suggested I should take his place as victim for to-day's Roman holiday. I could, of course—and did—plead my own inadequacies, and need not repeat that again as they will be only too obvious in a moment ; but the answer to my plea, as far as I remember, was that such inadequacy would only provoke a really intelligent audience like this to more constructive thought ; and indeed it is true that there are few greater stimuli to one's own activity than to see another's clumsy fumblings (witness our impatience when we watch a friend trying a key in a lock) so that perhaps it is fair to hope that my few remarks to-day will provoke you into tackling the matter yourselves. My final defence that it was inappropriate to invite me ever to speak here since all could read my views in the editorials of *Mental Health*, was countered, as far as I remember, by a delicate hint that no one ever read the editorial anyhow !

Besides being important, the subject is, of course, most extensive, and naturally Sir George could have given you a wider and rather different view ; but as we are deprived of that, I shall try to limit to-day's discussion to the way in which members of this Association, and others of their profession, can deal with the subject. I propose, therefore, to ask several questions in each field, and hope that my attempts to answer them, will, as I say, provoke you to a more complete exposition. These questions are :

1. What is meant by morale and mental health ?
2. What is our responsibility ?
3. What methods are we to use ?
4. What tools and skills have we ?
5. What parts of the field are most profitable to work in ?

Firstly, what are " Morale " and " Mental Health " ? Both are phrases we hear a lot of, and both are often very loosely used. Mental health in indeed, in some circles—I fear sometimes including the ministerial—used as a synonym for mental illness ; we hear of mental health statistics which are nothing but questionnaires on the facts of illness ; and though I am naturally in favour of thinking in terms of health, instead of in terms of illness, this will not happen by the mere substitution of one word for the other. The production of mental health is more than the avoidance of frank mental illness ; it is a positive effort for the complete well being of every mental function of the individual, and must, therefore, include the full expression of the individual's personality and the full development of his powers—intellectual and emotional.

Morale is interlinked with mental health and contributes to it ; is it the same thing ?

Group morale, however, is another matter, and it is in the sense of the group that " morale " is generally used ; high morale implies a group bound closely together by common aims, experience and stresses—supporting each other.

It is noteworthy that in groups of high morale the members suffer less from individual symptoms than those where morale is low ; and this perhaps is a commonplace. Disintegrating behaviour is unlikely.

Our Responsibility

The next question is, what part is to be played by ourselves, who are students of mental health with various kinds of training ? We all know that on this point we often become involved in a most bitter controversy in which (in polite circles) we are sooner or later accused of trying to usurp the functions of the Almighty or (in less polite ones) of being emissaries of the Evil One—and carefully chosen and trained emissaries at that ! I feel though, that this needs clarification. It is first essential to keep a discussion on ethics separate from a discussion of the mechanics of behaviour. Of course, as citizens we are all entitled to express our views on right and wrong—and life would be dull if we did not

do so—but I do not claim that a psychiatrist has any special title to speak on ethics, but only on the psychological mechanisms of behaviour. The same, I take it, applies to you as members of the National Association of Mental Health. We are exactly the same case as the surgeon whose job it is to heal his patient's broken arm, and whose interest lies in its return to full use, and not in whether that use is for good or evil purposes. This at least seems to me to be the logical conclusion, for I can see nothing in the training of the surgeon or psychiatrist which gives either the right to be regarded (by others or himself) as an authority on ethics. If we agree here, we must still admit that the difficulty in practice is that dividing lines are not so easy to draw in psychiatry as in surgery and that the psychiatrist seems always on the verge of ethical problems ; for the reason that ill use of the mind seems to him to be itself a symptom of ill health ; that is, it is difficult to distinguish bad behaviour in the sense of evil behaviour, from bad behaviour in the sense of sick behaviour. There are perhaps several causes for this ; in the first place, ideally *healthy* mental behaviour comes in most of our minds to be equated with ideally *good* mental behaviour ; it is indeed hard to define either and thus difficult to distinguish their opposites. Secondly, even those who find it possible to make a clear distinction in the abstract between these two, still sometimes find it difficult to decide in which category they should place a given example.

With these difficulties at the onset, it is obvious that practical difficulties follow. The study of disease leads naturally to a desire to study methods of prevention ; and mental illness is no exception. So the psychiatrist is inclined to feel that he must prevent *sick* behaviour, and study the factors which affect mental health. This is reasonable enough. But it is very easy for him to be led into feeling that he should also prevent *bad* behaviour and study the factors which affect good. This claim inevitably leads to conflict with politicians, judges, policemen, soldiers, managing directors and all concerned in maintaining discipline or accustomed to protecting society and is responsible for some of the criticisms already quoted. On the other hand one can sympathize only too readily with the psychiatrist's enthusiasm and public spirit.

Can we make this claim by comparing it again with surgery ? We agreed that the surgeon's aim was to cure the arm ; but what if that arm were known to him to be going to be used for an illegal purpose—to wield a gangster's gun ? Should he still cure it ? It seems to me that as a surgeon his duty is still to do so ; though, of course, when the arm is well, as a citizen he may have the duty of trying to prevent it getting a gun. To take another example, a prisoner-of-war camp—should a surgeon prisoner take an opportunity of maltreating his captor, to serve the interests of his own country ? It is possible that this has occurred, and been praised ; but it is, of course, on the assumption that it will not occur, and that the surgeon will always put his professional standards above his national interest, that an international agreement, the Geneva convention, is based. It is on such international agreements that the world, as well as to the nations concerned, depends for increasing co-operation, and any loss is thus deplorable.

If this is true of the surgeon, it must apply too to the psychiatrist or to any other social worker, who must stick to his own field and resist the desire to take his authority outside ; he has no more right to pontificate on ethics than any other citizen—(perhaps I should also add, no less right either ; but, if and when he acts as a citizen he must make it clear that he is doing so, and that he has shed his mantle of psychiatric authority—not an easy task).

If I have unduly laboured this point, I hope you will forgive me ; but I believe it to be fundamental and even if it is accepted by you to-day as obvious, it is not so obvious to many who are less educated. Indeed we constantly meet two misconceptions, the opposite of each other. One is the belief that psychiatrists and their allies are anxious to take over the responsibilities of the control of human behaviour, national and international ; this belief fills them with horror ; the other—perhaps even more embarrassing to us—is the desire for us to do so. One might indeed compare the attitude of the average man to the psychiatrist with that of the owner of a djinn rising unexpectedly out of a brass bottle : first, he exhibits very considerable awe : second, the awe decreases but much suspicion persists ; and third, as the djinn proves his usefulness, his amiability, and as his resemblance to a human being, increases, he is met with familiarity and sometimes a pet name. Finally the owner's increasing demands for miracles or magic drive the djinn to desperation, or perhaps to seek refuge in his bottle. I fully realize that the need for better national and international relations is

urgent, perhaps as never before, and I believe this is a reason for us all to exert the greatest influence we can. But surely the way to do this is by using our talents and training in the field for which they are best fitted, and not by frittering them away in other projects for which we have no skill. This counsel (to dig only in our own fields) is perhaps disappointing—but if any find it so, he can console himself with the fact that we have in our own territory enough work to keep us occupied for a generation.

Next, we must discuss which part of this work is likely to be the most profitable, what methods we should pursue, and what tools we have at our disposal. This meeting, composed as it is of representatives of various branches of the social sciences, is, I feel, a particularly appropriate one for such questions to be asked.

Methods

If then we are claiming to play a part as scientists, we must do so in the ways laid down for other sciences ; we must follow a threefold path.

This is described emphatically in a series of most telling adjectives by L. J. Henderson, whose words (quoted by Elton Mayo)* were " an intimate, habitual, intuitive familiarity " with the subject ; a " systematic knowledge " ; and " an effective way of thinking ". To obtain these he had recommended " hard, persistent responsible, unremitting labour "—" accurate observation of things and events ; selection, guided by judgment, born of familiarity and experience, of the salient and recurrent phenomena, and their classification " ; finally, " the judicious construction of a theory, a modest pedestrian affair ".

This is the path which all the natural sciences have trodden ; it is the path which we must tread too. There are no short cuts, and the keynote is patience and persistence and pedestrianism.

Tools and Skills

If we consider next our tools, we must admit that they are often inadequate or even imperceptible, and our skill primitive. The natural sciences have long passed the days when they were developing their earliest tools and skills, but if we can think how much they owe to the microscope or the telescope, we can realize how early we are in the development of our tools. Our lack of skill has been roundly condemned by Mayo, who has compared us unfavourably with all the natural sciences. I think this is a little hard. Mayo's suggestion was that we should acquire the skill of communication. His words are worth quoting. " I believe that social study should begin with what may be described as communication ; that is, the capacity of an individual to communicate his feelings and ideas to another, the capacity of groups to communicate effectively and intimately with each other. This problem is beyond all reasonable doubt, the outstanding defect that civilization is facing to-day." He could not be more emphatic.

With this I think we should all agree, but I think too that we can claim to be beginning at least two methods to this end—though I should be the first to admit they both need a great deal of development.

Firstly, there is the art of obtaining information, in which, no doubt, the technique of listening plays a large part. This is of benefit in at least one side of communication ; and most of us have perforce developed this to some extent in our profession. By contrast we do not seem to have been so successful in developing our skill in the other side of communication—that is imparting new ideas.

Secondly, there is the skill of interpretation—that is the unravelling of the underlying influence of behaviour. This must be practised by the psychiatrist and to an extent by his allies. Although no doubt various analytic techniques provide an understanding of deeper matters, I do not think it is right to say that understanding can only come by analytic methods, and I feel sure that many of you (who have not had the privilege of analytic training) will agree that you do in fact obtain some understanding of many pieces of individual and group behaviour without it. Again in parenthesis, it is interesting and rather sad to find that those whose skill is great in interpretation—in the sense of understanding—are not necessarily as expert in interpretation in the sense of explaining what they understand to others.

Subjects

The next question is, on what subjects can our methods and skill rightly be used ? We must readily admit that there is no lack of these, even within our prescribed scope, so that we need, after all, waste no sympathy on those who are anxious to work.

The fields in which we can work are many and varied ; each no doubt attracts different people ;

Mayo, E. (1946). The Social Problems of an Industrial Civilization. Harvard University Press.

industry, the structure of Society and of the family, education, vocational guidance and selection ; in all these relations between individuals and groups are at the root. May we consider a few examples ?

In industry the urge is for more and yet more productivity ; we are assured that on this depends our national survival. Many factors influencing productivity are, no doubt, material ; many others are psychological. In the midst of this struggle we find the most glaringly illogical behaviour—strikes which gain nothing but disrepute for their leaders, managers whose " efficiency " produces go-slow, men with excellent technical skill promoted to positions where social not technical skill is required. Illogical behaviour of this kind in an individual would indicate study of emotional roots of his actions. Can we doubt that this needs a similar approach ? Besides these examples, there are also in industry, many tensions between the different levels of the hierarchy, and of course between management and the workers, which would surprise the simple-minded doctor used to working as one of a team.

The relationships which exist in Society, national and international, are as much deserving of study ; illogical behaviour is equally common, and tensions so obvious as to need no emphasis. Again there would seem a strong case for the work of scientists trained in interpreting unconscious motivation. Another point was made by Mayo ; co-operation between individuals and groups is woefully inadequate and inefficient. We simply do not know enough about the reasons that lead two individuals or groups to collaboration, or to combat. Here again, study and patient observation is wanted.

In other fields, such as education and vocational guidance, we may find frequent examples of behaviour directed by unconscious complexes, and of group tension ; and it is perhaps an interesting reflection of the latter that those engaged in teaching are almost the only people left who are recognized to need one-third of their year as holiday—that is away from the site of tension. But here perhaps this is not the major problem of psychology ; more important is the application of tests for aptitudes and for intelligence, to the training for the professions and trades. Again, what are the factors which influence the transfer of ideas from one person to another ? Is the result of research on this applied to teaching generally ?

It seems to me that each of these fields would benefit from the appreciation of these points. Trained scientists would gradually acquire familiarity with the observed facts of each, and then a systematic knowledge ; later, an effective way of thinking, if developed, would provide a new approach to the problems I have already mentioned as examples of illogical behaviour and tension. There is no suggestion, that the work and experience of those already in the field would be lost or superseded—only that it might be amplified. After all, the illustrations I have taken, have not, so far, been satisfactorily dealt with by existing methods.

This is perhaps enough to indicate the width of the field of mental health, seen from various angles from which study may occur. I do not of course in any way deny the value of the established medical method—learning about health from illness ; and there is no doubt that much of value can come from this. But by far the greater part of our resources of money and workers are already directed on to the study of the sick, and my purpose to-day has, therefore been to stress the other side. The estimates for expenditure on treatment and on research are sometimes in the neighbourhood of 20 : 1, so that we have a long way to go to adjust this balance.

May I finish by summarizing very briefly the points I have tried to make :

1. The study of the mental health of Society is one which is urgent to-day.

2. The social scientists whose branches are represented here to-day can play a great part in this study.

3. Their approach must follow the path of any other science, and consist of three steps, the unremitting labour of ascertaining facts and so gaining familiarity with the subject, the classification of the subject, and the judicious construction of theories. May I repeat again—these must be " modest pedestrian affairs, that is they must not go too fast and they must expect to be frequently knocked down ". Unless this path is followed, we must lay aside all claims to authority as scientists, and have no more (but no less) than any other citizen.

4. We have certain skills to work with—the techniques of eliciting facts and of interpretation, which we must and can develop.

5. There are many parts of one field, which could bear the application of these methods. These are all of fundamental importance to our everyday life, and to the future of our civilization.

Mental Hygiene as an Academic Discipline at the University of Basle

By C. M. SENN-DÜRCK, Basle

From the Seminar on Mental Hygiene, University of Basle.

I

Through the efforts of Dr. Fritz Hauser, the chairman of the board of education, and the city council of Basle, a chair of Mental Hygiene was established at the University of Basle in the spring of 1937, and Heinrich Meng, M.D., was appointed to fill it. From 1928-35 Dr. Meng served as an instructor at the psychoanalytic institute connected with the University of Frankfurt-am-Main and together with Dr. Karl Landauer had been co-director of the policlinic for mental diseases at that institution. In 1933, Dr. Meng moved to Basle where he taught psychology and education in the University extension department from 1933-37. From 1933 on, Dr. Meng has been a member of the " Institute for Modern Methods of Education " at Basle. The chair of Mental Hygiene at Basle University was converted into an extraordinary professorship in 1945.

It was decided that Mental Hygiene should be taught at the University in the following manner : one hour a week was devoted to lectures to members of all faculties. A second hour was held especially for members of the medical, law, and other faculties according to the direction in which interest in the subject developed. (See section VI.)

As time went on, a demand for a special seminar arose. Students as well as young physicians, lawyers, social workers, theologians and others, wanted to discuss special topics in connection with mental hygiene. With the aid of private funds, a library (now containing over two thousand publications) and seminar room was established in 1943.

II

It was neither surprising nor unexpected that Mental Hygiene as a new discipline—like everything that is new—would encounter resistance. (It is only about forty years since the American C. W. Beers and the Swiss living in America, Adolph Meyer founded it as a branch of medicine.) The question of whether Mental Hygiene was really a science had been enough to make its introduction into the University classroom difficult.[1] In addition there were objections to psychoanalysis which Dr. Meng considered the psychological basis of Mental Hygiene. A comment of Freud's sums up the situation :

> " It is a matter of general knowledge how often in the history of scientific research, new discoveries which later turned out to be valuable and significant were at first met with intensive and stubborn resistance."*

While the controversies regarding the subject were debated and still continue to be discussed, Dr. Meng proceeded to build up his new field. He was at once optimistic and critical as was Freud in his time about psychoanalysis :

> " It sticks to its field of endeavour, seeks to solve the latest problems of its observation ; enriched by experience, it advances always unfinished, always prepared to withdraw or change its theories. Just as Physics or Chemistry, it is ready to admit that its highest concepts are unclear, its principles only adaptations to present knowledge, and it awaits the results of future research for a clearer understanding."†

III

Some of the subjects treated in the lectures and seminars were : " Prophylaxis of Neurosis and Crime ", " Question of Training as conditioned by Inheritance and Environment ", " Problem Children and Delinquency ", " Mental Hygiene at Various Ages ", " Mental Hygiene in the Everyday Life and Crises of the Individual ", " The Sociology and Mental Hygiene of Marriage ", " Mental Hygiene and Prophylaxis of Diseases ", " The Significance of Mental Hygiene for Sociology and Mass Psychology ". Special attention was devoted to questions of the prophylaxis of war. Several semesters of lectures during and after the second world war were devoted to this subject.

* *Die Widerstände Gegen die Psychoanalyse, Gesammelte Werke, Vol. xi, p. 225.*
† *Psychoanalyse und Libidotheorie, Gesammelte Werke, Vol. xi, p. 29.*

The instructor had no model to go on in teaching Mental Hygiene, and Basle can therefore be considered the first experiment in this field. Three questions arose out of this :

1. Can Mental Hygiene, as a subject, be taught ?
2. Is there enough interest to make teaching it worthwhile ?
3. Can other disciplines draw any advantages from Mental Hygiene ?

The experience of twenty-three semesters of lecturing on this subject shows that all three questions can be answered in the affirmative. It is not only possible, but now more than ever necessary to handle psychosomatic diseases, maladjustment and crime prevention—and particularly the problems of mass psychology and the prevention of war—from the standpoint of medicine and especially from that of psychiatry, psychology and sociology. An extract from a lecture given in the winter semester of 1946-47 about the prevention of war, is an example of the method of teaching Mental Hygiene.[2] A few sentences from another lecture portray the tone of instruction in Mental Hygiene :

> " This means pulling together for the building of the future, especially a productive future without war. For this, people with a sense of personal and social responsibility are needed in addition to a sound economy, social justice, and a truly ethical procedure.—Work and the possibilities of satisfying the mental, economic, and social needs of every individual are not *goals*, but *requirements* for a real order and freedom. One of the most urgent tasks of all peoples is to fulfill these requirements."

We should like to add that the creation of the best " milieu " and the training of young people to accept the responsibility for the development and preservation of humanity in its political, cultural, social and economic activities are phases of the evolution of Mental Hygiene.

IV

The personal view-point of the instructor to these problems of a new social order is of great importance. The student, consciously and unconsciously, examines critically the instructor's view-point, convictions and personality and uses it as a means of identification or resistance in his own maturing personality. We should like to show, as far as it is possible, how the position taken by the instructor influences the teaching of Mental Hygiene. He is of the opinion that despite many regressions into barbarism, and despite numerous standstills, it is historically possible to show that humanitarianism is on the rise.

This very moment—enriched by our experiences of the pre-war world, two world wars, and the resulting chaos—is the time to learn what caused the collapse of that world and what should be done to prevent it. The "old world" was unable to satisfy the mental and physical needs of the great masses. War was one of its most effective integrators. The experience of war and crisis worked against a productive peace by destroying faith and co-operation. Productive peace needs solidarity without war or the necessity for war. Mental Hygiene attacks the problem from the mental side and strives to inform the people in key positions (such as physicians, sociologists, lawyers, statesmen, and teachers) of its findings. It is not sufficient merely to describe the ills of society, but to found a scientific discipline which shall be able to correct them. In other words, scientific abstraction coupled with resolution can further the cause of humanity despite chaos, regression, and obstruction. This will not follow automatically, but will succeed through the efforts of individually and socially responsible persons.

V

Let us compare our instruction in Mental Hygiene with the requirements set forth by others in this field. Von Gonzenbach, in his contribution *Mental Hygiene as Taught at Technical Universities* considered Mental Hygiene as an educational rather than an academic subject. This line of thought has been followed at Basle University. In addition, it has been one of the instructor's chief tasks to point out the wide ramifications of Mental Hygiene, how it affects all of science as well as everyday living. It is shown how Mental Hygiene occupies a key position between scientific research and practical life. Without losing contact with medicine in general and particularly with psychiatry and psychoanalysis which are vital for Mental Hygiene, the attempt has been made to put the forces of the mind and the discoveries of science to work in order to create the right kind of living and working conditions—in short, the best " milieu " of which we have previously spoken. Here we see the close relationship between Mental Hygiene and Sociology which has been emphasized in the courses.

Stokvis's work in medical psychology showing mental-physical interplay has also been brought out in the lectures. Through statistics and pictures, the process of "somatization" was made clear and understandable. The findings of psychosomatic medicine are of particular significance for Mental Hygiene. Films—for instance those showing the phenomena and legal standing of—hypnotism have also been employed as a means of instruction.

VI

Since 1937 the interest of the students in Mental Hygiene has increased in a very encouraging way, considering that no examinations in this field are given as yet. The first time the course was given (summer semester, 1937), thirty-seven people took part in it—one-third students and the other two-thirds, listeners—and through the twenty-three semesters that the course has been given, thirty has been the average number of students per semester. The majority of them were from the natural science and philological faculty. The average number of listeners is forty. That medical students are so sparsely represented at the lectures can be explained through their particularly heavy schedule as well as the fact that Professor J. E. Stachelin includes Mental Hygiene in their psychiatric instruction.

Three main classes compose a study group :

1. Class composed of students and listeners who are admitted for one or both of the regular study groups each semester.
2. Class consisting of students and listeners who through many semesters, experience in the lectures and study groups, are well acquainted with the work. They meet, according to the need, to deal with scientific or practical problems of Mental Hygiene without being limited by regular semester schedules. This group concerns itself with preparation for congresses in Mental Hygiene or related fields, with translations of articles in foreign languages, with cataloguing and making scientific extracts from books and periodicals, and with participation in or planning future courses and lectures. In addition to the scientific publications of the instructor and his associates—as for instance in the collection : *Psychohygiene, Wissenschaft und Praxis*[3] —there are also collaborative releases to periodicals.[4] In common with the Swiss National Committee for Mental Hygiene we have tried to keep as many teachers, social workers, and parents, as possible in touch with our work.
3. Group made up of "corresponding" members.

Since 1943, experts in related fields or in Mental Hygiene itself have from time to time given lectures for study groups. Work in theory is considered the basis for practical work in Mental Hygiene. The varied contributions of the corresponding members ensure that the danger of the study groups degenerating into pure theorizing is avoided. Moreover, visits to educational establishments, orphanages and mental hospitals—in other word to those places in which Mental Hygiene is of practical use —serve the same purpose.

The prerequisites of Mental Hygiene are continually to test and re-define its limits and possibilities. Mental Hygiene is only one link in the chain of human endeavour. As it exists in Basle, it seeks within its limited means—scientific research and practical experiment—to help in the construction of a new society without war or social crises.

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Portrait of Jane*

By HER MOTHER

It wasn't until Jane was nearly eight years old that we knew definitely that she was not merely very stupid, but that her stupidity was such that she could never take her place alone in the world. " Half-wit ", " dim-wit ", " dumb-bell ", all the names which we had teasingly called her normal elder sister, suddenly had a hideous reality when we used them for Jane, and we quickly stopped.

Looking back I realize that I had had many hints that Jane was sub-normal. She learned to walk and to talk rather later than other children, but that did not worry me at all. She was healthy, large, cheerful, and in my eyes very pretty, and I never wanted a daughter of startling brilliant brains, I wanted daughters that were strong, and happy, and affectionate.

The first moment I remember feeling a wave of panic was when Jane was about six. That was in the war, and we had evacuated to Scotland. There was a parents' day at the village school, and all the proud mothers went up to watch a play and some prize-giving. Mid-morning there was a break, and the children were handed bottles of milk and straws. I noticed that Jane was having trouble removing the top off the bottle, and managing the straws. Looking around I saw that children much younger than Jane were having no difficulty at all.

At that instant I glimpsed the truth, and felt faint. I spoke to the schoolmaster, and he told me that she was undoubtedly rather clumsy and stupid, but that there was no need to worry—she would grow out of it.

We Learnt the Truth

The next eighteen months the situation deteriorated. We moved about Scotland following Jane's soldier father, and Jane went to several schools. The reports grew more serious. If a child cannot read at five or six, it is not important. If she cannot read at seven and a half, something is very wrong. At last we went to a famous child specialist in Edinburgh and were bluntly told the truth ; Jane was just over the borderline, she simply did not have enough intelligence to take her place in the normal world.

A nightmare feeling enveloped us—this could not happen to us. There was no other case in our family ; we had, in fact, unconsciously considered ourselves a clever family ; if not brilliant ourselves, we lived in the reflected glory of uncles and grandfathers who had done well in the professions. We saw four more specialists in London, asking and asking " what can be done ? " It took us a year to realize that at the present time, in Jane's type of case, the medical profession has no solution. There was nothing to be done.

I think, at this period, while we were always acting to help the child, we were actually thinking almost entirely about ourselves. There is a very strong instinct in all parents to be proud of their children. Quite modest people will bore you with tales of the miraculous progress of their young, in which they see themselves reflected. When you find your child is a " half-wit ", you feel very ashamed at first, and later you feel very humble. You certainly feel very sorry for yourself.

We learned a great deal about backward children. We visited " special " schools and read many books. As our friends learned of our problems we found that we were not alone in having a backward child, and we learned of many cases quite close to us that we had not known existed. People do not go about talking of relations who are a bit " queer ", but as soon as they find that you have the same problem, they are anxious to pour out their hearts.

The official reports told us that three to four per cent. of the school population are placed in the mental deficient class. These depressing statistics were an enormous comfort to us : slowly our problem fell into perspective. There was no more reason for us to be ashamed of a backward child than there was to be obnoxiously proud of a clever child—children just fell into different groups, and you just naturally loved and protected them however they turned out.

We were lucky to place Jane in a boarding school for " special " children, in the country. Here her days were filled with a busy routine of classes that she could follow, and she was much happier than she had been in the normal school, bewildered by lessons that were gibberish to her; she learned to read, to knit, to dance, to sing. to make her bed and to wash dishes. We were

* *Reprinted by permission, from* EVERYWOMAN, *January, 1950. " People in the Making, No. 17. The Backward Child."*

delighted in her progress and took pride in what she could do, and we stopped worrying that she probably would never learn to write properly, and that the chances of her ever learning to add or subtract were remote.

She came home for holidays and, now that her problem was generally known among our friends, we found a great number of people who shared the burden of looking after her. She is of a sunny cheerful nature and friends would take her for a half day, and she would help with their shopping or house-work. A responsible person must always be with her, which would be a great strain if the task was not shared. Ninety-nine per cent. of the time she behaves quite satisfactorily, but you cannot be sure.

Her Sister Understood

There was a morning when I sent her out to get a newspaper from a shop quite close by, and she came back with the newspaper and a volume of children's stories, which she said she had brought home to read. The fact that she had " shoplifted " the book had no meaning for her. My heart leapt, and for a moment I thought I heard a policeman's steps approaching the house ! I dashed to the shop, and my heart did not stop pumping until I had paid for the book ! Since that day I have not let her go shopping alone.

The war ended when Jane was eleven, and her elder sister, who had been evacuated to America for five years, returned. I worried a great deal about her sister's reaction and imagined she would be as ashamed and embarrassed as I had been. How wonderfully wrong I was ! She is four years older than Jane and has a tremendous protective feeling towards her and, with the vitality of youth, is often much better able to cope with Jane than I am.

I have learned since that older brothers and sisters of backward children usually handle the situation with love and gentleness, and understanding. When Jane did surprising things like singing to herself on buses, her sister thought it was very funny, gave her a poke and told her to be quiet ; while if I were tired, and Jane made herself conspicuous, I tended to feel embarrassed and miserable.

What of the Future ?

Of course, like all parents, we think of the future, and wonder what will become of Jane when we are dead. We haven't much money to leave her and we do not wish her to be a burden to her sister, who will, no doubt, have her own family and its problems before many years. We would hate to think that she might be put into a public institution among some really bad cases.

We hope that she will end, as other backward children have ended, in some simple supervised job that she can manage. We have heard of girls who have worked on farms under some kindly farmer's wife, or who have worked domestically in the country. We have found people everywhere so kindly disposed, and Jane herself so good-natured and adaptable, that we dare hope that she may find her niche and become as useful, in her way, as the normal child. If Jane had been born a hundred years ago of a village family, and had never been expected to read and write, to add and subtract and cope with ration books and petrol coupons, she would probably have passed as normal, though eccentric.

Jane is now fifteen, and I have just come back from a very happy weekend with her. I took her away from the school on Saturday to buy some necessary clothes. Like all girls, she took great interest in the purchases and in the tea, with many cakes, that we consumed. I do not think that anyone we passed in the shops or in the street noticed anything abnormal, but perhaps they did as, at Jane's suggestion, I bought two balloons, and possibly a tall girl of fifteen and her middle-aged mother do look a little strange walking down the main street with one large red and one large yellow balloon waving in the wind behind.

But I have at last reached the point when, if Jane is happy, I am happy too, and quite oblivious to what people think of our conduct. Perhaps we have started a new fashion in Worcestershire and perhaps, when I return next month for another short visit I will find all adults in the main street carrying balloons, and very pretty it will look.

The Editor regrets that it has not been possible to include in this issue, the fourth article on " Maintenance of Mental Health ". The series will, however, be resumed with the next issue.

THE SOCIAL ADAPTATION OF INSTITUTION CHILDREN

This was the subject of a research undertaken by a team appointed by the National Association for Mental Health, and generously financed by the Nuffield Provincial Hospitals Trust.

The team consisted of Dr. Frank Bodman (Director), Miss Margaret Mackinlay (Educational Psychologist) and Miss Kathleen Sykes (Psychiatric Social Worker). The Report, as it stands, is not being published, but a summary of it has appeared in the *Lancet* (28.1.50), and it is hoped that other sections may be printed elsewhere. A few points of general interest are noted here.

During the research, fifty-one children (nineteen girls and thirty-two boys) who had spent three years or more in institutions were studied together with a control group of fifty-two school children living in their own homes. Two of the institutions were modern " grouped " cottage homes ; the remainder were Homes of various types. In addition it was hoped to make a comparable study of a similar sized group of children brought up in foster-homes but great difficulty was experienced for various reasons, in obtaining access to these, and only twenty-three could be studied, not all of them fully.

The project, as planned, provided for a follow-up of every child seen in a Home, six to twelve months after leaving and to visit them again twelve to eighteen months after the original enquiry. It was not, in practice, found possible to adhere rigidly to this timetable, though the general aim of seeing every child again after the first visit as well as the people with whom he was then living, was, in the main, satisfactorily achieved. The children in the other groups were followed up after an interval of about a year.

To ascertain social capacity, Doll's Vineland Social Maturity test was used in every case in addition to the Revised Stanford-Binet Test and others given by the psychologist.

The report contains a description of the various types of Homes used for the investigation and discusses the points of difference between them. Differences in " atmosphere " are interestingly recorded by the social worker ; dealing with the social attitude of the " Homes " child to strangers, she writes :

> " The children's experience clearly varied, but it was only the exceptional Home which had achieved anything like a natural attitude. One's reception varied from the competent and friendly way in which one might be met at the station and entertained with considerable poise and general conversation while waiting for a local bus, to the suspicious and reluctant attitude shown by a child commanded to come to the " office " for an interview of whose object he had no inkling. Quite apart from the lack of preparation in the latter case, such an attitude to a new situation must be based on general experience and reflects something about the child's upbringing which is of great importance to him in his personal relationships in the world later."

Follow-up visits to Homes revealed the children's longing for someone who would take a continuous personal interest in them, as despite the arrangements made by many Homes for keeping in touch after leaving for work, this did not fully meet the need.

> " It was one of the hardest things about this investigation from the point of view of the social worker, that we should be debarred from giving active help or encouraging the permanence of one personal link."

It was frequently recognized by many of the people consulted that much more attention should be given to devising a good After-Care scheme, ensuring close co-operation between all who had been or were now concerned with the child.

The psychologist's section of the Report describes and discusses the tests given to the Homes children, and to the children in the control group. It further discusses the subsequent interviews which sought to elicit information from the children about the type of work they wanted to do on leaving school, and to find out what was their attitude to school. As a general rule a more friendly one was found in the control group and there appeared to be good staff-pupil relationships in all the four control schools visited.

With regard to the Homes children, the psychologist notes that the schools to which they went :

> "Tended to regard them as inevitably problems, inevitably educationally backward, and frequently also intellectually dull. (This impression has been strengthened by more recent school visiting in connection with later work.) While admitting the very considerable possibility of the children being all these things, it is felt that in some cases the school's reaction has been excessive and has tended only to exacerbate the problem."

The general conclusions reached as a result of this investigation are summarized by Dr. Bodman as follows :

1. The children brought up in institutions were less mature socially than those in the control group, as measured by the Vineland Social Maturity Test.

2. This relative lack of maturity is shown in fewer contacts with the community, and with the outside world, whether by organized social activities, the radio or press. Less advantage is taken of the opportunity to explore the neighbourhood or to travel any distance from home. Less initiative is shown in taking responsibility for himself or making practical plans for his future.

3. A little more than a third of the difference in maturity can be attributed to lack of opportunity and the restrictions associated with institutional life.

4. Thirty per cent. of institution children had no contact with any relatives.

5. Less than 6 per cent. of institution children had no friends while in the institution, but over 30 per cent. were friendless after leaving the institution.

6. While less than a quarter of institution children belonged to some kind of youth organization compared with more than half the control group; on leaving the institution another 20 per cent. joined organized social activities, while of the control group more than a quarter abandoned youth organizations.

7. Nearly five times as many girls in the control group compared with the institution girls, admitted an interest in boys. There was not much marked difference amongst the boys. One boy in eight institution boys and one boy in five of the control group showed an interest in girls.

8. Only 40 per cent. of institution children were successful in obtaining the occupation of their choice, compared with nearly 60 per cent. of the controls.

9. Yet only 22 per cent. had changed their jobs compared with over 35 per cent. of the control group.

10. Rather more than one in seven institution children failed in their first job. Except for one boy they were all of a dull, if not very dull intelligence.

11. A greater proportion (over a third) of institution children expressed themselves as looking forward to further promotion or acquiring further skill; less than a quarter of the controls showed this ambition. This ambition appeared to be associated with at least average intelligence.

12. A very striking discrepancy appears in the family histories of the two groups of children. Amongst the institution children 17·6 per cent. had relatives in mental hospitals, another 17·6 in mental deficiency institutions and 37·2 per cent relatives who had been reported to have committed anti-social behaviour. Amongst the control group, there were no relatives suffering from mental illness or guilty of anti-social behaviour : 11·5 per cent. of the control group had mentally defective sibs and nearly a quarter had neurotic relatives.

13. The very high proportion of children with relatives of proved defect, disease or instability of mind (72·4 per cent.) suggests that contributing causes to their relative social immaturity are inherited constitutional factors.

14. Indeed when all the children, institution and controls, are regrouped according to parentage, whether of sound mental stock, or of unstable parentage, it is found that the differences in social maturity are exactly the same as when they are grouped according to the environment in which they have been raised.

15. This finding suggests that constitutional factors are at least as important as environmental factors in the subsequent social maturation.

News and Notes

Psychiatric Community Care

In the *Lancet* of February 4th, there appeared an informative article on "The Future of Community Care", dealing with the Scheme so successfully carried on by the National Association and brought to an end with the withdrawal of the Ministry of Health grant on the coming into force of the National Health Service Act in July, 1948.

To emphasize the effect of the cessation of this Scheme before Local Health Authorities are themselves in a position adequately to undertake the work, the writer quotes a statement made by Dr. Louis Minski in the annual report of the Belmont Neurosis Hospital, Sutton, for 1948-49 :

> "One great difficulty which social workers have found since July 5th, 1948, is the obtaining of social histories in respect of patients living in distant parts of the country. This work was formerly undertaken by psychiatric social workers from the National Association for Mental Health and in most cases they have now ceased to function. Nowadays there is often no psychiatric social worker available in the district where the patient lives and the local M.O.H. has to be approached. He may have no one on his staff with experience of psychiatric work and the report is often of little or no value. Similar difficulty is also being encountered in arranging after-care for patients because of the lack of psychiatric social workers. In some districts, after-care consists in referring patients to a psychiatric clinic which may be the last thing which is required. I am afraid after-care as understood by us in the hospital has almost ceased to exist."

In conclusion, it is suggested that the Service might again be made possible through the help of "one of the rich voluntary funds"—at least until there is something else which can take its place.

Social Workers in the Mental Health Service

The Committee on this subject set up in July, 1948, under the Chairmanship of Professor J. M. Mackintosh, M.D., F.R.C.P., issued, in April 1949, an Interim Report, which it was hoped might have been made generally available. It has, however, been decided to publish only the Final Report, and meantime the Ministry of Health has sent to Regional Hospital Boards, Hospital Management Committees and Local Health Authorities, a circular giving the Committee's short-term suggestions on methods of dealing with the present situation arising from the acute shortage of trained workers.

The recommendations are as follows :

1. Fuller and better use should be made of married psychiatric social workers in part-time appointments.
2. The recruitment of men into the Mental Health Services should be encouraged.
3. The term "psychiatric social worker" should be restricted to those persons who hold a University Mental Health Certificate.
4. Efforts should be made to economise in the use of the services of fully qualified workers. It is noted, for instance, that they could be freed from a good deal of clerical and office routine work, which could be assigned to clerical assistants. which could be done by clerical assistants.
5. Efforts should be made to develop the joint use of senior qualified workers by agreement between Regional Hospital Boards, Hospital Management Committees and Local Health Authorities.

We understand that the Ministry is not drawing attention to other recommendations made in the Interim Report dealing with the possibility of helping to meet the shortage by instituting an emergency scheme of training, by reason of the fact that they would entail some expenditure which at the present time cannot be sanctioned. In view of the desperate need, and the fact that lack of workers seriously militates against the efficiency of the Mental Health Service in its social aspects, this is surely to be regretted.

World Federation for Mental Health

A generous donation is being made towards the budget of the World Federation by the Josiah Macy, Junior, Foundation of New York. The donation will be £15,000 a year for the next three years, though for the second and third year it is conditional upon the Federation raising from other sources at least £60,000 annually. An anonymous British donor has given £7,500 to be used during the next three years in meeting the salary of a Director.

Generosity on this scale is enabling the Federation to make a start with its work, but the question of how to place it on a permanently satisfactory financial foundation, with an adequate office in Geneva, is causing considerable anxiety : it is estimated that a sum of approximately £30,000 per annum is needed if the organization is to pull its weight in world affairs. At present thirty-three countries are represented in the Federation and there are sixty-two member societies from whom some help may be expected. Individuals wishing to be kept in touch with the Federation's activities, are recommended to subscribe to its Bulletin (5s. per year) to be obtained from its London office, 19 Manchester Street, W.1.

On February 17th, the British Standing Committee of the Federation arranged in London, an "International Symposium" on "Mental Health within the Family and the School" when the speakers were : Dr. A. Repond (Switzerland), Professor W. Line (Canada), Professor Fr. H. C. Rumke (Holland) and Dr. J. R. Rees (Director of the

Federation) with Professor J. M. Mackintosh in the chair.

Third Annual Meeting, Paris

Attention is drawn to the Third Annual Meeting of the Federation to be held in Paris, by kind invitation of the Ligue d' Hygiene Mentale) from Thursday, August 31st to Thursday, September 7th, 1950. The main topics to be considered (mostly in small working groups) are : " Mental Health in Education ", " Occupational and Industrial Mental Health ", " Mental Health Problems of Transplanted and Homeless Persons ", " Problems of Leadership and Authority in Local Communities."

The meetings are open to members of member-associations of the Federation and full particulars may be obtained from the Secretary, 19 Manchester Street, London, W.1.

Leeds Regional Psychiatric Association

Professor T. Ferguson Rodger, Department of Psychological Medicine, Glasgow University, addressed a meeting of this Association held in Leeds General Infirmary, in November.

Professor Rodger described his experiences as a member of the Sub-Committee on Mental Health of the World Health Organization and discussed the principles for mental health organization which this Sub-Committee had formulated. The Committee was representative of psychiatry in Britain, U.S., China, Czechoslovakia, Brazil and India. The facilities for psychiatric treatment throughout the world were generally inadequate to meet the demand—grossly so in Asiatic countries. The need for preventive measures was paramount ; yet even in the advanced countries prevention was a relatively new field. The most suitable field of development of preventive services is the Public Health Service which must establish an organization equivalent to that which it has provided for dealing with the problems of communal physical health. Such Mental Hygiene Departments would require the assistance of research workers in sociological and psychological aspects of the work. The International Sub-Committee regard mental health work among University students as of great importance as these individuals would in the majority undertake responsible positions in the community.

In discussion members emphasized the importance of instruction in the aims and methods of psychiatry for influential laymen such as industrialists, trade union officials and teachers. The importance of the Health Visitor, and her part in imparting to parents knowledge on the management of children was also urged.

Scottish Association for Mental Health

At the Annual Meeting of this Association, held in Edinburgh on October 15th, 1949, it was decided to substitute for " Mental Hygiene " in its title, the term " Mental Health ", and a new Constitution was approved. The crowded public meeting which followed was addressed by Dr. J. R. Rees, who took as his subject " World Mental Health Begins at Home ".

In the summer of 1949, a resident week-end Conference was held at St. Andrew's University on the work of Local Voluntary Associations for Mental Health, attended by forty-five men and women in key positions. In October, the Association arranged, in Glasgow, an eleven-day Training Course for workers in the mental deficiency field, and several members took an active part in the Post Graduate Course for Medical Officers held at Glasgow University in the same month.

At the request of the Scottish Council for Social Service, the Association submitted a memorandum on the welfare of the mentally handicapped, for incorporation in a joint memorandum presented by the Council to the Secretary of State's Advisory Council on Disabled Persons. The Advisory Council subsequently requested the Association to submit another memorandum dealing with the welfare needs of the mentally handicapped and on ways of meeting them by voluntary effort.

At the Assembly of the World Federation for Mental Health in Geneva, the Association was represented by Professor T. Ferguson Rodger, Chair of Psychological Medicine, Glasgow University.

A new Local Voluntary Association for Dumfries has been formed following on the holding of a very successful meeting in November, 1949.

Miss Isabel Laird resigned her post as Organizing Secretary of the Association during the year, and an Interim Secretary (Miss Mary Baker) was appointed, The address of the Edinburgh office is now, 41 Charlotte Square, Edinburgh 2.

Mental Health in South Africa

In the current Annual Report of the South African National Council for Mental Hygiene, some interesting developments are recorded.

The Special Schools Act, 1948, is now in operation, and under it, grants-in-aid may be awarded to Clinics run by Mental Health Societies, which opens up a new range of possibilities.

The training of Social Workers, particularly those engaged in mental health work, is being actively considered by the Council who have made representations to the Joint Universities Advisory Board and the Committee of Enquiry into the Training and Employment of Social Workers. All the Mental Health Societies affiliated to the National Council now employ qualified social workers, as a result of which marked progress has been noted.

Shortage of institutional accommodation for mental defectives and for mental patients continues to be acute, but the opening of the Howick Institution for European defectives will bring some relief. It is intended ultimately that this institution shall provide for 1,500 patients, but at present only 400 males can be accommodated.

The Cape Mental Health Society, at the request of the Council, is considering the possibility of opening a Home for coloured mental defectives, as a " pilot demonstration ". The need for establishing standardized mental tests for assessing the intelligence of non-Europeans, has been brought to the notice of the Education Department.

A non-European Child Guidance Clinic has been started in Cape Town, serviced by five psychologists, two social workers, and several playroom assistants.

Connected with the National Council, there are now seven local Mental Health Societies—in Bloemfontein, The Cape, Durban, East London, The Witwatersrand (Johannesburg), Pietermaritzburg and Port Elizabeth. A record of their activities includes responsibility for Mental Treatment Clinics and Child Guidance Clinics, After-Care of psychiatric patients and mental defectives, Occupation Centres and classes for defectives.

This Report is indeed a record of solid achievements in many directions, and the appreciation of the South African Ministry of Health (Dr. the Hon. A. J. Stals) is expressed in a message conveying his good wishes to the Council of which he is Hon. President.

The Council's address is : 426 Empire Buildings, Kruiz Street, Johannesburg (P.O. Box 2587).

Child Care Courses

The University of London Institute of Education and Child Health has recently organized a Senior Child Care Course for the training of workers for senior posts in the field of Child Care. This Course is designed to equip men and women for Junior Inspectorships, for supervisory and tutorial posts in connections with workers in Children's Homes, for supervisory or tutorial posts in connection with Day Nurseries and similar work.

The course includes lectures and seminars on physical and psychological aspects of child care, on educational aspects and recreational activities, on homecraft and domestic aspects of child care and on social services. Special attention is paid to the needs of the deprived child and of the delinquent child and seminars are held on religious education and on tutorial methods. Visits to clinics, schools, children's homes, approved schools and other institutions are arranged throughout the year. Two months residential work in a Children's Home and Reception Centre is undertaken during the Course. Special observations and special studies are made by the students and a careful balance is kept between medical and psychological aspects of child care and between practical and theoretical work.

The purpose of the Course is to give those, who are already qualified and experienced in some aspects of the care of children a broader and more balanced knowledge of the whole field of child care and to deepen and widen their understanding of the physical and psychological needs of children.

Applications may now be made to the Secretary, Institute of Education, Malet Street, London, W.C.1, for admission to next session's Course commencing October, 1950 and finishing July, 1951.

Applicants should have had not less than five years experience in the care of children and be either certificated nurses, teachers or social workers or possessing a University degree or similar qualifications. Candidates will be selected by interview.

Epilepsy and its Problems

In the Report on the *Health of the School Child* 1946 and 1947, there is an informative chapter on Epilepsy which could well stand by itself as a pamphlet on the subject.

In outlining the development of educational provision since the passing of the Elementary Education (Defective and Epileptic Children) Act, 1899, it is noted that since the opening of Lingfield in 1905, Chalfont St. Peter in 1909, and Sass Moss, Cheshire, in 1910, only one day special school (for twenty-nine pupils) has been added to the list and there are at the present time only seven boarding schools in the whole country, with accommodation for 696 children. Complete information as to incidence is not yet available, but the probability is that in the school population the proportion of educable epileptics is 0.3 per 1,000, and residential provision is needed for at least 1,500 of these.

The great majority of epileptic children do well in ordinary schools, and the fact that 80 per cent. of those in Lingfield and Chalfont were reported in 1946-47 to be below average intelligence, shows that the main need is for more schools for those who are educationally subnormal.

In a discussion on the curriculum and organization of residential schools, emphasis is laid on the importance of providing facilities for activities out of school hours—sometimes omitted owing to shortage of staff—and on the value of sending the children home for holidays, a practice not invariably encouraged by medical superintendents. The Report is uncompromisingly dogmatic on this point :

> " . . . the one massive, overwhelming argument in favour of sending a child home for holidays is that he ought to maintain as close a relationship as possible with his family and so experience the intimacies and the ups and downs of family life."

a plea which is equally valid for every other type of handicapped child in a residential home or school.

The association of " behaviour problems " with epilepsy has, in the past, been the subject of over-statement, and it is noted that the inevitable linking of the two was always deplored by Dr. Tylor Fox who used to express the opinion that he doubted whether one in ten of epileptics living outside institutions possessed the epileptic temperament. One of the smaller special schools, it is true, has said that 25 per cent. of its pupils were " difficult to handle " but the writer of the chapter under review, refers to the part played by "boredom in too

institutional an environment " in producing problems of the kind. The establishment of a unit in one of the schools for maladjusted epileptic children is, however, a future project.

In addition to the educational aspect of this problem, this chapter of the Report gives a clear summary of the different types of epilepsy on prognosis and on treatment, and it concludes with a section on " Public Opinion and Community Care ", touching on the question of employment and on the community's attitude towards the epileptic.

There is thus an urgent need for a representative national organization " to champion the cause of the epileptic "—the chapter concludes ; and we are glad to be able to state that plans for such a scheme are now under active consideration. In them, the National Association is co-operating and it is hoped that a preliminary conference may be called shortly, to which further reference will be made in our next issue.

Ascertainment of Educationally Subnormal Children

In the Report referred to above, there is an interesting chapter, written for the guidance of Education Authorities and School Medical Officers, on this all-important question.

Stress is laid on the imperative need for a proper selection of medical officers upon whom falls the responsibility of deciding whether a child's " disability of mind " is such that he needs special education or whether he must be pronounced as ineducable within the school system. This work, it is stated :

> " calls for judgment founded on deep understanding and knowledge, reinforced by extensive experience of children, both normal and abnormal. It requires very special aptitudes and attributes, particularly patience and a capacity for friendliness with children."

Moreover, to carry it out efficiently, a medical officer should be acquainted with the various types of schools now provided so that he may fully understand the import of the recommendations he will make.

A warning is given against exclusive reliance on the results of intelligence tests, and the need for allowing sufficient time during the examination for gaining the child's confidence is pointed out. The confidence of the parent must also be gained :

> " . . . it is *their* child who is being examined. Therefore they have a right to be given sympathetic and friendly attention, partly in order to obtain their co-operation but chiefly to give them an understanding and appreciation of the problem which causes them much anxiety. . . . Much unhappiness can be dispelled by a straightforward and human approach with a sympathetic understanding of the parents' difficulties."

In a borderline case, where diagnosis is difficult, the examining officer is urged to give the child the benefit of the doubt, by postponing the making of a decision until after a further period of observation, or of trial in a special school, and the fact that no special school exists in the area must never be allowed to influence the final decision.

Another important point is stressed at the conclusion of this chapter—in the paragraphs headed " Ineducable Children ". If a diagnosis of ineducability is made, Section 57 (3) of the Education Act requires the Local Education Authority to inform the parent in writing of this decision. It is, however, urged that such a notification should not merely be sent through the post but should be delivered personally by a social worker, health visitor, school nurse or some other experienced welfare officer of the Authority, in order that the matter may be sympathetically explained and questions answered.

> "On examining children", we are told, "whose parents have appealed to the Minister against the issue of a report, it has been found over and over again that the parents do not really contest the view of the Authority as to the educability of the child, but owing to the notice having been phrased in official and sometimes terse language, they fear that it presages immediate and permanent removal from his home and their care. This fear naturally causes much distress and unhappiness."

This chapter is primarily concerned with " human relations " and we welcome its warmth of tone and sympathetic understanding.

Amending Regulations

In connection with this question of " ascertainment ", we draw attention to the recent issue of Amending Regulations (Statutory Instruments, 1949, No. 1970) on procedure in cases of children referred for examination by reason of educational subnormality.

The original Form of Report (H.P.2) received some criticism in that it had to be filled in exclusively by the School Medical Officer and no provision was made in it for the statutory services of an educational psychologist (where one is employed) in assessing intelligence.

The revised Form now gives to psychologists due professional status and Part II comprising not only a record of the results of Intelligence Tests (including performance tests) but also " general observations " may be filled in and signed *either* by a psychologist *or* by the School Medical Officer.

Cerebral Palsied Children

Those who are interested in cerebral palsied children will be glad to know that in *The Health of the School Child* (1946 and 1947), a whole chapter is devoted to the subject.

Some information is given about experimental research work now being carried on in this field (e.g. at St. Margaret's, Croydon, and Queen Mary's Hospital, Carshalton) and reference is made to

enquiries as to incidence which have been undertaken in Sheffield, Bristol and in Wiltshire, as well as to American experience. It is emphasized, however, that the study of the subject is still in its infancy and that " we are only at the beginning of a tremendous task ", the implications of which are sympathetically outlined in this very human presentation of the cerebral palsied child's urgent needs.

These needs are also revealed in a note that has reached us from a mental health worker who is employed by the Education Authority of a small County Borough as a home teacher of six cerebral palsied children all seriously crippled. Growing out of this work is a social club for less handicapped older children and a class to help them in subjects in which they are backward at school. A Parent's Association, affiliated to the British Council for the Welfare of Spastics has been launched. The interest of the local Scouts has been enlisted, and it is hoped in time to start a special troop.

It is particularly interesting to know that these activities grew out of an enterprising piece of pioneer voluntary service, consisting of efforts made to help an individual child, followed by a Saturday morning experimental class sponsored by the children's parents with the help of the Red Cross car service.

Art and Music Therapy

Readers who are interested in the use of art and music in the treatment of mental patients, may like to know that a report of a one-day conference on " Art and Music Therapy " held by the British Council for Rehabilitation in the spring of last year, appeared in the October issue of the Council's magazine *Rehabilitation* (32 Shaftesbury Avenue, W.1. Price 2s.). It includes contributions from Dr. E. Cunningham Dax (Netherne Hospital, Coulsdon), on " Music Therapy ", Mrs. H. I. Champernowne, on " Painting and Modelling as an Inner Process ", Miss J. Guy on " Modelling and Pottery ", and Miss N. Godfrey on " Painting " ; Dr. W. J. T. Kimber (Hill End Hospital, St. Albans) gave an address on " The Patient with the Paint Brush ", and an account of the Arthur Segal Method in Art Therapy was given by Miss Elsie Davies, (Art Therapist, City Sanatorium, Birmingham). Mr. Adrian Hill, referred to the " giant strides " made by Art Therapy since he first launched it as an experiment at the King Edward VII Sanatorium in 1942.

Forthcoming Conferences

The following Conferences—all of which have a bearing on mental health—are amongst those taking place during the next few months :

British National Conference on Social Work, Harrogate, April 19th to 23rd. Subject : " Social Services in 1950, the Respective Roles of Statutory Authorities and Voluntary Organizations." Particulars from Conference Secretary, 26 Bedford Square, W.C.1.

Royal Sanitary Institute. Health Congress at Eastbourne, April, 24th-28th. Subjects include " The Administration of Care and After-Care Schemes ", " The Role of the Family in National Life ", " Administrative Problems due to Vague or Complicated Legislation ".

National Marriage Guidance Council Annual Conference, Rustington, near Littlehampton, Sussex, May 6th-13th. Particulars from Marriage Guidance Council, 78 Duke Street, London, W.1.

International Conference on Social Work, Paris, July 23rd-28th. Subject : " Social Work in 1950. Its Boundary and Content." At this Conference, the conclusions reached at Harrogate will be presented.

British Social Hygiene Council's Summer Schools. July 31st to August 14th, Seale-Hayne Agricultural College, Newton Abbot, Devon ; August 16th-30th, College Franco-Britannique, Cite Universitaire, Paris. Subjects " Biology and Rural Life " (Devon School) and " The Welfare of the Family " (Paris School). Particulars from British Social Hygiene Council, Tavistock House North, Tavistock Square, London, W.C.1.

Twelfth International Penal and Penitentiary Congress, August 14th-19th at The Hague. Particulars from John Ross, Esq., Assistant Under-Secretary of State, Department of Probation and Juvenile Delinquency, Home Office, London, S.W.1.

Second International Congress on Criminology, Paris, September 10th-19th. Particulars from the Organizing Secretary in the United Kingdom, c/o Institute for Scientific Treatment of Delinquency, 8 Bourdon Street, London, W.1.

Psychodrama

The Theatre of Psychodrama, New York, is holding weekly performances every Sunday evening until the end of May.

The productions are spontaneous and unrehearsed and result from the interaction between the stage and the audience, and they are regarded as a social experiment to demonstrate the possibilities of mass therapy.

Further information may be obtained from The Theatre of Psychodrama, 101 Park Avenue, New York 17, U.S.A.

CORRESPONDENCE

W.H.O. and Mental Health

DEAR SIR,—In the very excellent *Annual Report of the N.A.M.H.*, which has recently appeared, there is a section about the World Federation for Mental Health, and I would like to have the opportunity, if possible, of commenting on one sentence there.

In the penultimate paragraph on page 19, the Report says that the function of providing active and advisory services in the field of mental health had been " usurped " by the Mental Health Advisory Group of the W.H.O. This actually refers to the Expert Committee on Mental Health which the W.H.O. has set up, but I think the use of the word " usurped " is a little unfortunate, more especially since the setting up of the Expert Committee, which is an inter-Governmental body, was one of the recommendations of our London Congress in 1948, reaffirmed by the Executive Board of the World Federation. W.H.O. has clearly, therefore, implemented what was recommended and can hardly be said to have " usurped " any function. The relationship between the Executive of W.F.M.H. and the Mental Health Division of W.H.O. is a completely co-operative and satisfactory one.

Since I am writing to make this one small comment for the sake of accuracy may I also say how much we hope that the N.A.M.H. and all the other member societies in this country will take an active interest and play an active part in the development of the policies of the World Federation. We in the more privileged countries have a great deal to give to our less privileged neighbours, but we also get a very handsome return, in the way of new ideas and stimulation for any adventures in the international field.

I am, etc.,

78 Harley Street, J. R. REES.
W.1.

An Association of Patients

DEAR SIR,—May I suggest the forming of an Association of Patients on the lines of the Diabetic Association for those who have gone through Mental Hospitals and have recovered ?

This would be in no way connected with bodies which aim at revealing the defects in institutional treatment, and expressions of regret about what had happened in the past would be barred. The Association would aim at producing a hopeful and constructive outlook on the future by mutual encouragement and by the enlightenment which might come from the patients' point of view stated objectively. It is to be hoped that it would include medical men.

At present those of us who have been in hospitals for mental treatment in the past, have to overcome a sense of shame in admitting this fact. It is difficult to retain faith in our own personality, particularly if we have to express views which are not widely held. Though there has been some progress in educating public opinion by societies such as the N.A.M.H., there is still an attitude towards mental illness which sets it apart from all physical ailments to the detriment of healing processes.

The Association I suggest, would take the whole problem right out into the light of day and end the shamefaced hole-in-corner procedure, too common in the past. As my own doctor said to me, " it is a privilege to have gone through such an experience and come out an integrated man ". These words are rather too generous but they contain a measure of truth.

We have many things to be rightly ashamed of in the conduct which brought the need for mental treatment—just as those who eat too much or take too much or too little exercise, should be ashamed when these methods of living bring on physical illness. But we have no reason for shame—only rather for pride—that we have had treatment for mental illness which made us able to return to the world of men and women, there to play our part in the developing human species whose future—can one doubt it—is one of hopeful promise.

Yours etc.,

Borrers Platt, DAVID PEAT.
Ditchling, Sussex.

It is clear that the present desire for religion is great, whether in a confessional form, as a liberal faith, or in the belief in values transcending Man . . . Modern Science can only fulfil its promises of help through awareness that it can never entirely meet the deepest need of man, a need met only by the humble surrender to the " unknown ". Science can develop its full power only when imbued with religious consciousness in the widest sense.

PROFESSOR DR. H. C. RUMKE, Report given at Second Mental Health Assembly, Geneva, 1949.

Book Reviews

Social Biology and Welfare. By Sybil Neville Rolfe. 1949. Allen & Unwin, Ltd. 416 pp. 21s.

The introduction to this book consists of autobiographical notes " crystallizing the experience of some forty years ". The next four chapters deal in general terms with biological influences in relation to man and his environment. Five chapters follow, mainly concerned with normal and abnormal sex behaviour and the value of sound family life in different types of community. Chapters 10 and 11 give an account of the development of social work in the colonial empire, and include discussion of some current problems of social hygiene. The final portion of the book consists of a useful handbook on 25 social problems, including trends of population, illegitimacy, care of children, old people, mental health, prostitution, written by experts in these various fields, with well-selected statistical tables from Government reports.

There is much of value in this publication. The history of the growth of interest in, and study of the biological foundations of social science, includes material which will be new to many and should make the inheritors of the results of the struggle traced by Mrs. Rolfe, grateful for work so well done that it is to-day widely accepted as axiomatic.

But the book has serious faults which spoil its usefulness. Authors must of necessity interpret work to which they have given years of thought and action, and sometimes (as in Mrs. Rolfe's case) whole-hearted devotion, through their own characters and experience. But due regard should be paid to the work of others, and especially to those of the pioneers in various fields. This the writer has failed to do, in more than one instance. Her book thus loses historical accuracy and balance, and an impression of ungenerous and obviously biased criticism is given.

The thread of concern for the mental well-being of human beings runs through the entire book. But the sense of the mystery of the as yet scarcely explored country of the mind, seems to elude the author. If this and that were done, individuals would become adjusted or would not be born. The author does not suggest that failure to become adjusted to certain material or spiritual conditions may be one method of forcing human inertia to take another step on the way set for humanity.

" Religion " in this book becomes a method of improving human stock. This may be, and sometimes is, a useful by-product of the pursuit of knowledge of the eternal, but it is not its end and aim.

The author shows a tendency to equate sexual promiscuity and mental defect, which is quite unwarrantable. Statistics are given of certain studies of prostitutes or women in some kind of sexual trouble, which show a high rate of mental defect among them. But comparable statistics of the rate of the sexually promiscuous in groups of certified mental defectives are not given. The figure would probably be lower than Mrs. Rolfe would expect. There is failure to distinguish between the control justly given to society over the certified defective, and the control many wish to exercise over the " border-line " and unstable person. However passionate the desire of social reformers may be to save the human race from the tragedy of mental illness or defect, careful watch must be kept for the protection of those who are legally free and in control of their lives.

A fine courage shines through this book, but humility in the face of great mysteries is lacking.

K.B.H.

The Evidence for Voluntary Action. Edited by Lord Beveridge and A. F. Wells. George Allen and Unwin Ltd., London. 16s.

In the preface to *Evidence for Voluntary Action*, which is intended to accompany his " Report on Voluntary Action as a Means of Social Advance ", Lord Beveridge explains that

> " Organizations for Voluntary Action should be allowed to speak for themselves, as they act according to their own inspiration in serving society."

Thus the first volume is supplemented by the basic information on which its conclusions were founded, and together the two volumes provide a fairly comprehensive survey of the field which voluntary action covers in this country and, in addition, some valuable suggestions for the future.

The method in which the material is presented indicates the meticulous care exercised in the survey and the collection of the evidence. Part 1 is devoted to the Reports by Mass Observation, one being on the Friendly Societies from which several significant points emerge.

Other reports are on Mutual Aid and the Pub, Voluntary Services, and Aspects of Charity. The purpose of the latter study was " to discover attitudes to charity, reasons for giving to charity, and whether or no people considered that charity was necessary in the world of to-morrow ". Here again significant differences are revealed: " Middle-class people almost invariably discuss the effects of charity on the giver, working class people the effect on the recipient." Among the general sample little more than one in four persons thought charity " a good thing ", while one in five disapprove. Fifty-five per cent. had no opinion. Among panel members, " the vagueness is equally evident ".

Part III consists of memoranda on the finance

of voluntary action and is of importance to all voluntary organizations. The fourth part of the book is devoted to the publication of memoranda from fifteen organizations representing the wide variety of interests in the field of voluntary action. There is also a directory of some of the leading voluntary societies and an extensive, though not complete, bibliography on voluntary action. A valuable section of the book is that in which "memoranda by individuals on special topics" are included. The contributors are Lord Beveridge, Mr. A. F. Wells, Mrs. Joan Clarke, Mr. Roger Wilson and Mr. John A. Lincoln.

It is not possible here to deal in detail with the numerous and varied facts and suggestions which every section of the book contains. With its companion volume, *Voluntary Action*, much information, not previously available, is presented in such a form as to make for easy reference. The many statistical tables are comprehensive and varied, and in addition to the conclusions which are suggested every reader will find in them a basis for his or her own comments and hypotheses.

With public attention focussed on the future of the voluntary societies, the present situation calls for strict examination of their own affairs by all voluntary organizations. *Voluntary Action* and *The Evidence for Voluntary Action*, together provide much valuable material for this purpose.

J.S.

Understandable Psychiatry. By Prof. Leland Hinsie, M.D. The Macmillan Company, New York. 22s. 6d.

Perhaps the most remarkable feature about this remarkable book is its choice of title, for it would be hard to find a parallel for it, in its combination of flamboyant style and confusing content.

No doubt Professor Hinsie understands his own particular brand of psychopathological theory, but it is difficult for the reader to do so. Lip service is frequently paid to Freudian theory, and psychoanalytical terms are used in many chapters, but the meaning given to them in this book is frequently entirely different from that devised by Freud and accepted by most psychiatric workers. But, in addition, the author uses numerous other strange technical terms, many of which are entirely unnecessary and all of which are very ugly. As examples may be quoted "Psychalgia" (mental pain as opposed to physical pain or somatalgia); "Altrigenderism and Suigenderism" (apparently representing hetero- and homo-sexuality with some special obscure significance of their own) and "Psychoscopy" (which is defined as mental microscopy). The book is liberally spattered with sentences in italics. Some of these italicized passages contain points of importance and worthy of stressing, but the use of italics is so frequent, and much of the content is so banal, that they quickly cease to be of any value and become only an irritating interruption of one's reading.

According to the author's preface this book was written equally for the physician and the patient. Its intentions are clearly good and there is something of value, especially in its later chapters, if the reader will have the patience to extract these points from the mass of verbiage. It is, therefore, regrettable that the result as a whole is so confusing. In its present form it is likely to irritate the physician who reads it, confuse or disturb the patient according to his degree of insight and do a good deal to harm psychiatry in the eyes of its critics.

T.A.R.

The Biology of Mental Defect. By Lionel S. Penrose, M.D. Sidgwick & Jackson. 21s.

Many people hold very definite views which they do not hesitate to propound on this subject. For example a leading dignitary of the church recently advocated wholesale sterilization of mental defectives in an article published in a daily newspaper. Those who are interested in the social problem of mental inferiority would do well to study this new book on the subject by Professor Penrose. By so doing they will gain an insight into the extreme complexity of the problem and realize that it is one which cannot be solved by any single piece of dictatorial legislation. On the contrary, mental defect is an inevitable part of our social structure as it stands to-day. This is not to say that the dimensions of the problem may not be much reduced and the lot of particular individuals (whether patients or their relatives) much eased by proper social provision. Penrose quotes Arkansas, Arizona and Nevada as states in which no provision is made for mental defectives and shows that in those states there is an equivalent rise in the number of persons admitted to prison and he notes that in general it costs more to keep a citizen in prison than it does in an institution for mental defectives.

Throughout his book Penrose brings to bear an accumulation of scientific erudition in contrast to the moralising tone which permeates the older text-books of mental deficiency. He shows that modern psychiatry has little use for the legal concept of moral defect and points out that in general mental defectives are not less but more receptive in point of character training than ordinary individuals. He suggests that the origin of faulty habits which high-grade defectives may acquire, lies not so much in any innate propensity for wickedness as in a faulty social environment, and points out that the purpose of institutional care of such cases is re-equipment for a useful life in the community. In general he does not favour the mixing of high-grade delinquents and "psychopathic personalities" with well-behaved patients of a lower level. He shows that the result may be bad for both groups inasmuch as the bad behaviour of the delinquents may serve as a model for their less gifted fellows whilst the more intelligent patient who is committed to an institution from court or prison is contemptuous of the imbeciles

with whom he is confined and so prejudiced against any advice and instruction which he may be offered.

Penrose also deals admirably with the alleged threat to the national intelligence which arises in popular imagination from the alleged fertility of mental defectives. He explains that idiots and most imbeciles are sterile (though in fact some American states have been to some pains to reduplicate nature's work by sterilising many thousands of such patients). Apart from this the feeble-minded are also less fertile than the average, and it is among the dull and backward group who are not legally recognized as mental defectives that a really high reproductive rate is found. He gives grounds for believing that this phenomenon may not be so undesirable as is generally believed. He suggests that just as most defectives are the children of ordinary people, so too those who have made great contributions to civilization may come from parents in no way specially gifted apart from their ability to endow their children with special characters.

As to what constitutes mental defect Penrose explains that there is no such thing as " intelligence " in the abstract and that what the defective suffers from is a lack of various abilities which are more or less reliably assessed by standardized intelligence tests. He shows that in the main these tests were devised by those whose prime need was for verbal ability and that they do not necessarily give a reliable estimate of the practical ability of the subject. By the same token, he quotes with approval the opinion that formal education should be incidental to the training of the imbecile rather than its prime purpose. He does not adhere to the view that the intelligence of a child is fixed and unalterable throughout his life and views with the suspicion which it deserves, any estimate of intelligence formed before the age of five. On the basis of observations made on adopted children together with other facts he puts forward the tentative hypothesis that nature and nurture are of approximately equal importance in determining the intelligence level of an individual. Elsewhere he points out that whereas the share of " nature " is largely predetermined, the share of " nurture " is socially determined and therefore readily influenced so that the ultimate level of performance and social usefulness of the defective is profoundly affected by his upbringing.

In discussing the causation of mental defect, Penrose mentions a number of factors which have already attracted medical attention and some of which it may be possible to modify, by suitable measures of personal and social hygiene. These include the effect of German measles, mumps and other infectious fevers during pregnancy, incompatibility of parental blood groups, hitherto little studied errors of body chemistry which give rise to gargoylism and phenylketonuria. He mentions a number of interesting possibilities for research which include the effect on certain mental defectives of various pituitary hormones.

Professor Penrose's book is essential reading for all of those who have to deal with mental defect (a term which can be extended to cover at least 1 per cent. of humanity). The mathematical sections may be skipped by those whose talents do not lie in that direction, with little detriment to the main argument. It is to be hoped that a second edition will see an amplification of the clinical presentation for those unversed in the subject.

B.H.K.

The Infancy of Speech and the Speech of Infancy. By Leopold Stein, M.D. Methuen. 21s.

This book is difficult to classify because our knowledge of the era with which it is concerned is so slight that deductions based upon the slender factual evidence are scarcely capable of proof or disproof. Recognizing this the author modestly describes it as a " misadventure " and " a mixture of fact and fantasy ". It is in reality a scientific adventure into speculative realms—a profoundly interesting attempt to determine the probable origins of human speech and to describe the various paths and stages of its development.

Although the vast blanks in our knowledge of early man and of his prehuman ancestors are necessarily bridged by imaginative construction, this construction appears to be based on a careful collation of the evidence offered in the fields of anthropology, archaeology and philology interpreted in the light of the author's own long and specialized study of speech and language. What renders it particularly interesting is that this " scatter of facts " is assembled and considered, perhaps for the first time, by one whose profession both as doctor and speech pathologist enables him to relate them anatomically, psychologically and linguistically.

Dr. Stein suggests that the speech, or rather the pre-speech utterance of the infant, mirrors in little the probable development of language in the infancy of the human race, and he places on both his own interpretation of the psychological and emotional urges which determine the growth of each and claims that the theories here set forward have received support from the fact that " under their guidance it has been possible to re-integrate the speech of human beings inflicted with speech disorders ".

Not everybody will agree with his views but no one who is fascinated by the mystery of human speech and its development, can fail to be interested in the picture he builds up. The book is well indexed and includes some beautiful plates as well as text illustrations and diagrams.

J.D.

Personnel Selection in the British Forces. By Philip E. Vernon and John B. Parry. University of London Press. 1949.

Psychological work in the Services, during World War II, attracted a good deal of public attention. Indeed it rapidly acquired for itself a

magical status. On the one hand a small band of relatively obscure people was added to the list of cultural scapegoats, whose machinations could be cited as excuses for failure to secure promotion, or who, if sufficiently propitiated by offerings of suitable symptoms, could easily be hoodwinked into providing a ticket for civvy street. On the other hand, it was predicted that the wholesale application of service methods to civilian life, in industry, education, and mental health, would solve many of our society's most difficult problems. Surrounded both by irrational hostility and equally irrational enthusiasm, the application of psychological techniques to service problems has suffered badly from the lack of authoritative and sober scientific appreciation. The present work by Vernon and Parry should do a great deal to redress the balance so far as the field of personnel selection is concerned.

It is a welcome feature of the book that it covers the work of all the Services. It is doubtful if anyone is as well qualified for this task as is Professor Vernon, both because of his very wide previous experience, and because he enjoyed the unique position of acting in consultant roles to two of the three services. The book is in two parts. In Part I, after an historical introduction, there are four chapters covering the organization and general procedures employed in " Personnel Selection in the Royal Navy ", " Other Rank Selection in the Army and A.T.S.", " Army Officer Selection ", and " Selection in the Royal Air Force ". Part II is devoted to a discussion of the general principles of vocational psychology, and to a thorough review of the main instruments it uses—biographical questionnaires, interviews, and the various kinds of tests. Scope and limitations, our present knowledge of the reliability and validity of the main techniques and their more important variants, are clearly set out, and ably discussed. Other pleasing features are the abstracts, short, but eminently readable, which precede each chapter ; the appendix of tests and their characteristics ; the valuable bibliography and excellent subject index.

Throughout, an attempt is made to keep in view previous knowledge, war-time developments, and possible future applications. This attempt to cover so much ground does, of course, have its drawbacks. Specialists in one or other of the fields described may feel, as this reviewer does, with regard to Army Officer Selection, that even the astonishingly efficient survey made, fails to do justice to the wealth of material with which they had first-hand contact, and perhaps more important, to the underlying implications of their work. But this is scarcely a legitimate grievance. The authors have succeeded in producing a guide-book of truly encyclopaedic compass and of great merit. It is both comprehensive and concise, lucid and terse, as well as stimulating without loss of objectivity. Its usefulness goes far beyond a mere description of what was done in the war and students of vocational psychology in this country are likely to regard it as the standard work for many years to come.

It is a truism that adequate vocational adjustment is a pre-requisite both of efficient social effort and of individual health. What contributions toward these aims can we expect from the powerful psychological technology growing in our midst ? Can we prevent its misuse as an instrument of subtle coercion in the hands of powerful groups ? Already our industrial society is becoming aware of a number of hitherto unsuspected and potentially dangerous concomitants of its growth toward the Welfare State. It could be, that the emergence of " human engineering " is also a symptom of approaching doom—the unrecognized doom which closes round those who fail to perceive the shift in values implied in translating " the psychological guidance of individuals " into " the classification of personnel ". As always, the only remedy is vigilance and understanding, on the part of both the public and psychologists. The primary understanding required is that of insight into human motives, and into the workings of a society based on the concept of ordered freedom, with its implications of a balance between equality and variety of opportunity, and an adequate freedom of choice for the individual. Vernon and Parry sense the dangers, and say a number of important and courageous things, but the issues are so grave and go so deep, that this aspect of applied psychology deserves a much wider and more prolonged discussion than it has yet received.

B.S.M.

Psychiatry for the Paediatrician. By Hale F. Shirley, M.D., Associate Professor of Paediatrics and Psychiatry and Executive Director of the Child Psychiatry Unit, Stanford University School of Medicine. N.Y. Commonwealth Fund. Oxford University Press. 25s.

This is an eminently competent and satisfactory book which should prove very useful to students, paediatricians and practitioners desirous of becoming familiar with the principles of child psychiatry. Approach to the subject is psycho-biological and the child is seen as a developing organism reacting to factors in its own make-up and in the family and social environment. The author pays due respect to Kanner whose influence is obvious in the attitudes adopted and the presentation of the subject matter.

In a preliminary section on basic concepts in child guidance, analytic concepts are simply, though not necessarily inaccurately presented, but in actual discussion of the emotional life attention is directed to manifest behaviour rather than to psychopathology. Discussion, too, is at the level of every-day life and includes such terms as " self-respect " and " sense of achievement ", although a glossary of psychiatric terms is offered for the assistance of paediatricians.

The second chapter on development and habit training will be found particularly useful, discussing as it does, the primary development of the child and the emotional needs that must be supplied by the environment. The common disturbances of habit training are related to interference with development or failure in the environment, and appropriate measures discussed.

Subsequent chapters deal with physical, intellectual, emotional and environmental factors in the development of the child and the syndromes of child psychiatry are appropriately discussed in this context, with happily selected illustrative cases. One would mention for particular comment the sections on emotional factors in physical disturbance and emotional problems of the organically sick. In both, the advantages of the psycho-biological approach are apparent.

The non-psychiatric reader will find the subject of intelligence testing adequately dealt with and usefully related to the educational level to be anticipated and potential social capacity.

While the chapter on treatment does not aim to go beyond environmental modification and direct assistance to parent and child on the basis of understanding, supported by the prestige of a sympathetic physician, nevertheless the summary of the nine principles of treatment is one that could be studied with advantage by the most expert child psychiatrist.

Well set-out and with an adequate index and wide bibliography, this book is a valuable addition to the literature of child psychiatry. K.C.

A Psychiatrist Looks at Tuberculosis. By Eric Wittkower, M.D. With an Introduction by John Rickman, M.D. National Association for Prevention of Tuberculosis, Tavistock House North, W.C.1. 12s. 6d.

Dr. Eric Wittkower is known throughout the world as an expert research psychiatrist in the psychosomatic field. The puzzling variety of reactions of the human body to the invasion of tuberculosis is made more clear by this study. The findings of 2½ years investigation show that by assessment of the previous personality of the patient, some prediction of the course of the illness is possible.

This survey in no way invalidates the other aetiological factors, such as adverse living conditions, but offers some explanation as to why the patient falls ill when he does. The main conclusion is that the individuals who develop tuberculosis seem to have an inability to deal adequately with their aggressive impulses and are prone, though for varying reasons and in different ways, to turn against themselves. The prognosis is better in the over dependent and leaning types. It is a pity that there has not been a control group and it is hoped that such an investigation will be done at a later date.

There is an introduction by Dr. John Rickman, which contains an appreciation of Dr. Wittkower's interviewing skill. This book is to be recommended to all those who wish to see the patient as a whole and to understand the kind of personality he possesses and its influence on the course of his disease.

A.T.

The Child is Right. By James Hemming and Josephine Balls. Longman's. 7s. 6d.

This book is rightly described by the publishers as "A Challenge to Parents and Other Adults". In their attempt to paint a picture of life from the child's point of view, the authors show somewhat unusual imagination. In fact many of the stories are almost too painfully real and only too familiar. The child, for instance, who, finding himself separated from his mother in the bus, is seized with panic and starts pushing and shoving everyone in his attempt to get out ; the two-and-a-half year old who wants to climb on his mother's knee and is told "not to come too near in case he knocked the baby's head" ; the adolescent whose attempts to appear grown up are constantly being misunderstood and laughed at, and so on.

Although there is much useful advice in this book, it is primarily descriptive and therefore very readable. It should be a help to those who want to understand but do not always stop to think.

C.H.S.

Freud and Christianity. R. S. Lee, Vicar of University Church, Oxford. James Clarke & Co. 1949. 204 pp. 8s. 6d.

Dr. Lee has attempted (as others have done before him) to effect an accommodation between Freudian theory and Christian doctrine. The task is formidable enough to daunt all but the most sanguine apologist ; and it would be as idle to pretend that Dr. Lee succeeds, as to deny that much of what he has written ought to be read, by Christians and Freudians alike.

The author seeks to mediate : but a mediator "is not a mediator of one". And virtually all the concessions required to establish the concordat are, it seems, to come from the Christian side. We are invited to accept, without cavil, comment or hesitation, the most orthodox Freudian dogma, presented here with praiseworthy lucidity though of course in summary form. It is by the test of this "ur-Freudian" corpus that Christianity is to be judged, and by this test is found wanting. Even the chronology of the Bible is at fault if, and because, it does not follow the master-pattern. The modifications of traditional Christian teaching which are needed to make it "square" with psychological truth are so radical and far-reaching that they amount to a major operation : indeed, the result would be a religion lacking many of the authentic marks of Christianity. The darker side of life, and its theological corollaries, do not appeal to Dr. Lee. The way of "obedience" (along which so many neurotics have passed to new life and

health) is dismissed as "super-ego religion". God is a "friendly" person, revealed in a very "human", "natural" and "friendly" Jesus—a Christ who, it is safe to assert, could not possibly have spoken more than (say) half of what is attributed to Him in the Gospels. To do justice to Dr. Lee, he would very likely agree that He could not have done so.

Whatever may be said about Freudian theory and practice, it is clear (and this book adds to the evidence) that they cannot be easily turned into an instrument for the criticism and reform of religion. If Dr. Lee had not claimed, in his preface, to demonstrate "how psycho-analysis can cleanse Christianity of non-Christian elements", it would have been easier for the sort of reader for whom his book is presumably intended to weigh his other assertion, that it can also "give deeper insights into the true qualities of human life". For in this (though the terms of reference are so widely and boldly drawn) he is more successful, and some of his *obiter dicta* are forceful and to the point.

G.L.R.

Mysterious Marriage. A Study of Morality of Personal Relationships and Individual Obsessions. By E. Graham Howe. Faber & Faber. 15s.

When one reads a book of Dr. Howe's, one is left at the end of it with a sense of frustration. One asks oneself if one is stupid and fails to understand the written word, or else one says to oneself that it is as wonderful and profound as a Stravinsky symphony of which one has understood only a fraction. For those who like an obscurantist approach, this book will stimulate a great deal of reflection, but whether it will help to make their own little rifts in the marital field narrower, is a matter for speculation.

A.T.

British Journal of Psychiatric Social Work. Obtainable from A.P.S.W., 1 Park Crescent, London, W.1. 3s. 6d.

The third number of the official organ of the Association of Psychiatric Social Workers, published in November, 1949, contains some extremely interesting and well-written articles by members of the Association. The subject matter is varied and covers a field as widely separated as the work of the Duly Authorized Officer and the responsibility of the Psychiatric Social Worker in helping the client to make full use of his religion. Of particular interest is the article on "Home and Career: Woman between two Worlds" which is the result of an investigation made by the Parents' Group of the Association, into the problem of the married woman with a professional career. Their generosity in allowing themselves to be used as guinea-pigs will be appreciated by those who are anxious to find a workable solution to this problem.

Apart from a note on the Second Assembly of the World Federation for Mental Health and one on the Child Guidance Exhibition given by Hill End Clinic in 1947, no space has yet been allotted for news on or book reviews. It is to be hoped that if and when the Journal is published more than once a year, these will be added.

C.H.S.

Mental Hygiene in Public Health. By P. V. Lemkau, M.D. McGraw Hill Book Co. 38s. 6d.

This book cannot be over-praised, because it opens a wide field for the activities of Medical Officers of Health. It arises as a result of a series of lectures given in an American University by a Public Health Officer, who has had the vision to see that mental health is as important as physical health.

The new Health Service Act has laid much stress on hospital and clinical care and treatment, but the preventive side of medicine has been passed by. It is very necessary that in the mental health world every measure should be taken to prevent the development of mental illness, or to arrest it as soon as detected. This means that a Public Mental Health Officer must be aware of the early signs and symptoms of deviations from normal mental health, and make arrangements for early treatment in the community to prevent the development of the illness to such an extent that the patient requires hospital care. To this end he must understand normal emotional development and the beginnings of emotional abnormality. Lemkau's book gives this understanding. He indicates the kind of preventive mental health service that could be set up and also describes the development of personality so that a clear picture is given of the strains and stresses that give rise to early mental illness.

A description is given of the various Mental Health Services in the different States in the United States, and one feels that although some of them are ahead of us, others are not so well organized.

If Medical Officers of Health are looking for a new field to conquer, they should buy this book and use it as a text-book for the development of an enlightened mental health service.

A.T.

The Hospitals Year Book, 1949-50. Institute of Hospital Administrators, Tavistock House North, Tavistock Square, W.C.1. 37s. 6d.

This weighty year book, of 1,100 pages, includes directories of Government Departments, Regional Hospital Boards and Hospital Management Committees, Boards of Governors and Teaching Hospitals, Ministry of Pensions Hospitals and Voluntary Hospitals, Local Health Authorities and Executive Councils. An article on the Mental Health Services is contributed by Dr. Rees-Thomas.

Reference books as up to date as this one, are invaluable, and each such publication makes another welcome landmark in the still unfamiliar administrative landscape.

Film Reviews

Why Tommy Won't Eat. *16 mm. Sound. 20 mins. National Film Board of Canada, Sackville House, 40 Piccadilly, W.1.*

This film, which is in colour, deals with the principal reasons for healthy, normal development in children, and seeks to explain how to avoid feeding difficulties rather than how to cope with them once they have arisen. It stresses the well-known ideas of being elastic with regard to routine, allowing babies to experiment with their food even at the cost of some messiness, etc.

The story deals with one particular child who would not eat, and it explains that in that case the mother was at fault, as on the one hand she was too rigid and anxious, while, on the other, she was lacking in friendliness and understanding.

On the whole, the film is well balanced and pleasantly photographed. It gives a good sound basis of approach to this matter without going into great detail. It would be very useful as a basis for discussion amongst nursery school teachers, parent-teacher organizations, health visitors, and other similar groups.

E.H.R.

The Rocking Horse Winner. (*Featuring John Howard Davies, John Mills, Valerie Hobson and Ronald Squire.*) *90 mins.*

The appearance of a doctor and the death of a patient from extreme mental strain would seem the reason for a review of this film in *Mental Health*, but its interest for readers probably lies more in other details of the film that would not generally be labelled " psychological ".

The story, taken from one of D. H. Lawrence, is of a sensitive child, worried about his beautiful, idle and extravagant mother and her apparent need for money, who finds that by riding his rocking horse in a frenzy he can sometimes spot the winner in a race, but at great cost to himself. What I can spot as winning is a real growth in psychological understanding of ordinary characters ; but the ignorant and sensational treatment of mental abnormality must be counted as loss so far as popular psychological education is concerned, though it achieves its purpose of rousing tremendous excitement.

Not many years ago the mother would have been just bad and beautiful, idle and extravagant and selfish (as she is) ; neglectful, unkind and unfeeling, (which, on the whole, she isn't). She is understandable, likeable even, and, although her faults are the indirect cause of her son's death, the audience can pity her throughout the story, without demanding, as just retribution, a sense of overwhelming remorse at the end. The uncle, too, is a credible mixture of strength and weakness : the pillar of his sister's unstable household, genuinely fond of his nephew, a gambler through and through, he lets Paul go on with his dangerous game, as a character formed of these component parts certainly would. The innocence of Paul and the unreasonableness of his worry is high drama : " We've won £300 ! " he tells his uncle ; " 300 pennies, you mean ", says that astonished gentleman. Paul is puzzled and uncertain. " I thought it was pounds ", he says, but is not sure of the difference. As the house whispers in gathering crescendo, " must have money ", Paul casts his haunted face round the room, seeing, but without understanding, the luxurious furnishings and priceless ornaments on which his eyes fall.

Perhaps it is paying too high a compliment to psychology to give it all the credit for the subtlety of the character drawing in D. H. Lawrence's story and the presentation of this film, but it can claim, I think, that it has taught people that human personality is infinitely variable, and weaned them from satisfaction in the wholly good and wholly bad. It can certainly claim that it has increased their interest in the minds and behaviour of children.

There remains, however, the death from over-strain of the brain, accompanied by deafening orchestral music. It seems as though the cinema has learned that the mind is sensitive and delicate and liable to behave strangely under strain ; perhaps the time is coming when the other half of the truth will be told, that the mind is also tough, adaptable and resilient—but that, of course, is less dramatic.

P.E.W.

A Psychoneurosis with Compulsive Trends in the Making. *16 mm. 40 mins. Dr. R. MacKeith, Department of Child Health, Guy's Hospital, London., S.E.1.*

This is an interesting study of obsessional trends in a child of a highly obsessional mother, The mother was under psychiatric treatment throughout the child's early life, and the film is intended to show how this resulted in a modification of some of the child's own trends. It shows an extraordinarily interesting perfectionist drive towards physical skills on the part of a very young child who performed amazing feats in the first two years, but tended to deteriorate later and developed considerable anxiety.

The photography in this film is not particularly good, and is therefore trying to watch. The film, which is essentially documentary with no particular story, needs a great deal of explanation. In the opinion of the reviewer, it would be somewhat unconvincing to people who are not already converted to the psychological approach, and really it is suitable only for specialist groups.

C.H-S.

Recent Publications

THE COMMONSENSE PSYCHIATRY OF DR. ADOLF MEYER. Edited by Alfred Lief. McGraw Hill Book Co., N.Y. $6.50. London. 39s.

PSYCHOLOGICAL ASPECTS OF CLINICAL MEDICINE. By Stephen Barton Hall, M.D., D.P.M. H. K. Lewis. 21s.

PSYCHOSOMATIC MEDICINE. THE CLINICAL APPLICATION OF PSYCHOPATHOLOGY TO GENERAL MEDICAL PROBLEMS. By Edward Weiss, M.D. and O. Spurgeon English, M.D. Second edition. Philadelphia and London. W. B. Saunders. 47s. 6d.

*A PSYCHIATRIST LOOKS AT TUBERCULOSIS. By Eric Wittkower, M.D. National Association for Prevention of Tuberculosis. 12s. 6d.

*MENTAL HYGIENE IN PUBLIC HEALTH. By P. V. Lemkau, M.D. McGraw Hill Book Co. 38s. 6d.

MR. CARLYLE, MY PATIENT. A PSYCHOMATIC BIOGRAPHY. By Jas. L. Halliday. Wm. Heinemann Medical Books. 15s.

THE GROUP APPROACH TO LEADERSHIP TESTING. By Henry Harris, M.D. Foreword by General Sir Ronald Adam, and Preface by Brigadier A. Torrie. Routledge & Kegan Paul. 21s.

INJURIES OF THE BRAIN AND SPINAL CORD AND THEIR COVERINGS. Edited by Samuel Brock, New York University. Baillière, Tindall & Cox. 76s. 6d.

SOCIETY AND ITS CRIMINALS. By Paul Reiwald, doctor of jurisprudence, Reader in Criminology, University of Geneva. Wm. Heinemann Medical Books. 21s.

†BRITISH MEDICAL BULLETIN. PART 1. MENTAL HEALTH. Vol. 6. Medical Department, British Council, 3 Hanover Street, London, W.1. 10s.

†HUMAN RELATIONS IN MODERN INDUSTRY. By R. F. Tredgold, M.A., M.D., D.P.M. Duckworth. 8s. 6d.

THE ADOLESCENT AND THE FAMILY. By Stella Churchill, M.R.C.S., L.R.C.P., D.P.M. Cresset Press. 7s. 6d.

*THE CHILD IS RIGHT. A CHALLENGE TO PARENTS AND OTHER ADULTS. By James Hemming and Josephine Balls. Foreword by Lady Allen of Hurtwood. Longman's. 7s. 6d.

LIFE AND GROWTH. A SUPPLEMENTARY READER ON SEX EDUCATION. By C. M. Legge and F. F. Rigby. Faber & Faber. 6s.

A GUIDE TO INTELLIGENCE AND OTHER PSYCHOLOGICAL TESTING. By E. P. Allen Hunt and Percival Smith. Evans Bros. 4s.

†BACKWARD CHILDREN IN THE MAKING. By Charles Segal. Fredk. Muller Ltd. 7s. 6d.

THE CHILD AT SCHOOL. A PARENTS' GUIDE. By J. H. Newsom, County Education Officer, Herts. Penguin Books. 1s. 6d.

NURSERY INFANT EDUCATION. Published for the National Union of Teachers by Evans Bros., London. 5s.

* *Reviewed in this issue.*

Reports and Pamphlets

*THE HEALTH OF THE SCHOOL CHILD. REPORT OF CHIEF MEDICAL OFFICER TO MINISTRY OF EDUCATION, 1946 and 1947. H.M. Stationery Office. 3s.

APPROVED SCHOOLS. Eighteenth Report from Select Committee on Estimates with Minutes of Evidence, 1948-9 Session. H.M. Stationery Office. 4s.

NATIONAL ASSISTANCE ACT. Ministry of Health Circular (No. II-50, on Welfare of Old People. H.M. Stationery Office. 2d.

FAMILY LIMITATION AND ITS INFLUENCE ON HUMAN FERTILITY DURING THE PAST FIFTY YEARS. Royal Commission on Population, Vol. 1. H.M. Stationery Office. 4s.

ADOPTION OF CHILDREN (SUMMARY JURISDICTION) RULES, 1949. No. 2397 (L.32). H.M. Stationery Office. 4d.

ADOPTION OF CHILDREN (COUNTY COURT) RULES, 1949. No. 2396 (L.31). H.M. Stationery Office, 4d.

ADOPTION OF CHILDREN ACT, 1949. H.M. Stationery Office. 6d.

MINISTRY OF EDUCATION. List of Boarding Special Schools and Homes for Handicapped Pupils. H.M. Stationery Office, 1949. 6d.

LONDON COUNTY COUNCIL. REPORT OF CHIEF MEDICAL OFFICER AND SCHOOL MEDICAL OFFICER, 1948. Staples Press. 2s. 6d.

HOSPITALS DIRECTORY, ENGLAND AND WALES. H.M. Stationery Office. 3s.

THE EDUCATION AND TRAINING OF TEACHERS. UNESCO. Obtainable from H.M. Stationery Office. 1s.

THE INSTITUTIONAL TREATMENT OF DELINQUENTS. By Sir Alexander Maxwell, formerly Permanent Under Secretary of State, Home Office. Ninth Clarke Hall Lecture. Obtainable from Clarke Hall Fellowship, Tavistock House South, London, W.C.1. 1s.

THE CASSEL HOSPITAL FOR FUNCTIONAL NERVOUS DISORDERS, Ham Common, Richmond, Surrey. Medical and General Reports, January to July, 1948.

WOMEN'S EMPLOYMENT FEDERATION. Memorandum on Openings and Trainings for Women. Second edition, 1948. 2s. 7d. post free. 251 Brompton Road, London, S.W.3.

THE MARRIAGE RELATIONSHIP. Report of a Commission appointed by Society of Friends. Friends Book Centre, Euston Road, N.W.1. 9d.

† *To be reviewed in next issue.*

SUPPLEMENT TO "MENTAL HEALTH".
VOL. IX. NO. 3.

EIGHTH INTER-CLINIC CHILD GUIDANCE CONFERENCE

LONDON, SATURDAY, DECEMBER 3RD, 1949

ABBREVIATED REPORT

Chairman : **Dr. Alfred Torrie**

(*Medical Director, National Association for Mental Health*)

MORNING SESSION

THE PRESENT POSITION OF CHILD GUIDANCE

Dr. Alan Maberly

(*Consulting Psychiatrist, Kent and Essex Child Guidance Services : Chairman, Clinical Services Committees, National Association for Mental Health*)

I want, very briefly, to outline what we have been trying to do at the National Association for Mental Health to solve the problems that have arisen in Child Guidance largely as a result of the National Health Service Act. In 1944, when the Education Act went through, we felt that a very large part of our work had been done : Child Guidance was on the map ; it was an obligation of the Local Education Authority to organize Child Guidance Clinics, and we turned our efforts to increasing training facilities in order to meet the shortage of suitably qualified staff. There matters stood, until the National Health Service Act laid upon Health authorities the obligation of providing everyone with medical and, therefore, psychiatric treatment.

For guidance, the Ministry of Education, in August, 1948, published Circular 179, which is headed, *The School Health Service and Handicapped Pupils : Effect of the Establishment of the National Health Service.* The general principle is that the Regional Hospital Boards will, in agreement with the Local Education Authorities, assume administrative and financial responsibility for all arrangements. . . . In addition, where Authorities require the services of a specialist for the discharge of the functions which fall to them, e.g. for the ascertainment and subsequent examination and supervision of handicapped pupils . . . the Regional Hospital Board may in some instances, if desired, be able to make available the part-time services of a whole-time specialist in the Board's service.

But : "Local Education Authorities, however, will be in no way precluded from directly providing . . . any specialist service for school children which it appears to them desirable to provide notwithstanding the facilities otherwise available."

Those two clauses give powers either to the Regional Board or to the Local Authority to provide these services under which Child Guidance falls, but the Local Education Authority will, however,

> "remain responsible for meeting the cost of arrangements for the medical inspection of the pupils, including the specialist examination and supervision required in respect of the physical and mental disabilities of handicapped pupils in special schools."

Now follows the heading *Child Guidance.*

> "Child Guidance work of the type at present undertaken by Local Education Authorities is in the main an educational service closely linked with the school and home. Thus the needs of most of the children who are maladjusted, whether to a degree which calls for their ascertainment as handicapped pupils or to a lesser degree, can be met by social and educational adjustments. Much of the work is carried out at the schools in co-operation with the parents and teachers by the educational psychologists and specially qualified social workers appointed by Authorities. The educational, physical and psychiatric aspects of the work are, however, inseparable and at the Child Guidance Centres established by local Authorities the team of workers includes a psychiatrist and also, as a rule, a paediatrician."

Now we come to the sentence which has caused us all a lot of difficulty.

> "Some of the children may be found to need psychiatric treatment ; the Minister, in agreement with the Minister of Health, considers that these children should normally be referred by the authority to the clinics which will be provided in due course by the Regional Hospital

> Boards and which in some instances are already available ; similarly, these clinics will refer appropriate cases to the Child Guidance Centres."

In this proposal, the term "Child Guidance Centres" refers to any clinic, as we understand it, which is run by a Local Education Authority. The Child Psychiatric Clinic, on the other hand, is any clinic which is run by a Regional Hospital Board. That is a purely administrative distinction. The same team may staff both. One is a Centre, the other a Clinic. We felt that this particular paragraph was confusing. It states that the psychiatric aspect of the work of a Centre is essential: psychiatrists must be on the staff : yet it seems to imply that the psychiatrist's work must be limited to diagnosis, that if treatment is required, the child and parent must be referred to another Clinic where all the work is carried out again. We did not feel this to be a desirable position.

The only other clauses which concern us are two :

> "It will be open to Authorities to arrange, as and when practicable, for the specialist service required at their Centres to be provided by the Hospital and Specialist Services if they are of the opinion that the work of their Centres can be suitably organized on this basis."
>
> *and*
>
> "A part of the work at the Child Guidance Centres established by the Authorities is, however, concerned with the ascertainment of maladjusted pupils under Section 34 of the Education Act, 1944, and the Authorities will be financially and administratively responsible for the specialist service required for this purpose."

It is obvious, therefore, that the Child Guidance Service presented the Authorities, as it has so often done before, with an administrative problem. Whatever they did, the Local Education Authority remained responsible for supplying a specialist service in relation to ascertainment and, as far as Centres were concerned, they could supply the specialist themselves or ask the Regional Hospital Board to do it. The Regional Hospital Board could accept the invitation or it could decline ; but it remained the obligation of the Local Education Authority to supply the local Child Guidance Service if no one else did it. At this point I think it is imperative that we all remember that financial considerations, in the last resort, will govern what Regional Boards do. Some Boards will supply the service and some will not, and it cannot be said with any certainty that the Child Psychiatric Clinics which, according to this circular, will soon be available, will necessarily soon be available in any area at all.

Then, very briefly, I want to read you a quotation from a letter (drafted by Dr. Soddy, then Medical Director), which we sent in to the Authorities expressing our disquiet at this situation. We said that we felt that the proposal of this dichotomy in the Service "*would involve the running of a service for ascertainment of maladjustment and for educational treatment by one authority alongside a separate therapeutic service by another authority. Such a proposal has serious drawbacks, not the least being the use of two separate organizations to do what could be done more efficiently by a single body.*"

The drawbacks we suggested were many :

1. The ascertainment of emotional disorders in the schools would become the lone responsibility of educational psychologists, many of whom are now without clinical experience and who, with the continuation of such a system, would tend more and more to lack this essential experience.

2. To absolve the psychiatrist from responsibility for intimate contact with the source of his clinical material and for ascertainment of illness is a retrograde step contrary to modern trends in preventive mental hygiene.

3. To divorce the responsibility for diagnosis from that of providing treatment is widely condemned in medical practice as tending to irresponsibility on the part of the diagnostician and to unreality in the therapist.

4. Experience has shown that the work of the educational psychologist away from a clinical setting may become sterile and lose its distinctive contribution to mental health. This Association agrees with the view held by the Committee of Professional Psychologists (Mental Health) that any administrative measure tending to divorce psychologists either in work or training from clinical experience is to be deplored. We are agreed that clinical practice is an essential part of the work of psychologists in both the educational and therapeutic aspects of child guidance if the latter is to develop realistically. A proposal to establish parallel organizations cannot fail to accentuate a tendency (already regrettably apparent) to regard the training of psychologists for this work as something apart from that of the other members of the team.

5. A proposal which must necessarily split the team by sending one member out into the field and withdrawing another into a more clinical or hospital setting must be condemned as fundamentally disruptive to a movement which owes its distinctive contribution to the combination of psychiatric, psychological and sociological approaches in as close a connection with the community it serves as possible.

Lastly, we said :

> "This Association urges strongly that the lesson of experience is that all workers must be based on the clinic team, must owe allegiance to the team as a unit and must carry on their respective functions in day-to-day collaboration with other team members."

That is part of a memorandum which we sent in after the issue of Circular 179. We were assured, both officially and unofficially, that there had been no intention on the part of the authorities at either of the Ministries to separate diagnosis from treatment. They failed to understand how we could have read such an intention into the document. They gave us an assurance that any recommendation to refer to the Hospital Clinic would be made by the Child Guidance Centre and no child should be referred from the Centre to the Hospital Clinic if the psychiatrist at the Centre considered that he could treat the child properly at the Centre. This is important, because, although it is not intended by either Ministry that any idea of separation should arise from Circular 179, it is our experience, and I am quite certain it is your experience, that many Local Authorities are interpreting it in precisely that way.

Now, what has happened in the last eighteen months ? In effect, some of the old organizations have gone on more or less unaffected ; in other cases there have been very considerable changes.

Under the Regional Boards, we have established clinics such as the Tavistock Clinic and the Training Centre and the Hill End Clinic in Hertfordshire. There are Clinics connected with small voluntary hospitals, which now come under Regional Boards ; many of them have full teams, exactly equivalent to Child Guidance Centres under Education Authorities, but they are Child Psychiatric Clinics. There are what we know as Child Guidance Clinics, run in association with mental hospitals, or with children's hospitals, again with a full team, and known as Child Psychiatric Clinics. There are, here and there, Child Psychiatric Clinics set up by Regional Boards from scratch, usually beginning with a psychiatrist alone, and sometimes ending there. Then there are the Child Guidance Clinics in Association with Teaching Hospitals, independent of Regional Hospital Boards, independent of Local Education Authorities, many of which have full teams. There are the Local Education Authority Clinics still going on, as at Manchester ; about that you will hear from Dr. Burbury to-day.

Lastly, there are proposals for a combined clinic and centre which we feel might meet our point of view better than any other : that is a situation where the Local Education Authority continues to organize the clinic and to provide the Educational Psychologist and Psychiatric Social Worker, while the Regional Hospital Board appoints, in co-operation with the Local Authority, the Psychiatrist and seconds him, as it were, for service in the Child Guidance Centre. I call it "Child Guidance Centre" because we have to do that, as it is organized by the Local Education Authority, but it serves both functions. It serves the purpose of a Child Psychiatric Clinic in so far as it unquestionably carries out all treatment, serves the whole area, and takes every child, irrespective of the tvpe of school they attend. It is also a Child Guidance Centre and, therefore, it has one team and there is no question of a child, after full examination and diagnosis, being referred for treatment elsewhere.

I might just say here that this separation of function is probably worse for our patients than it is for us. We can doubtless all think of examples of separation of responsibility, and it is a state of affairs to be avoided in our field.

DISCUSSION

Dr. W. J. T. Kimber (*Medical Director, Hertfordshire Child Guidance Service*). The Child Guidance Service was started in Hertfordshire fifteen years ago (1934) with one clinic at St. Albans. It had three sessions every week, and was staffed by a full clinic team. To-day there are five clinics, which hold, in all, over the years, forty-eight sessions weekly. The main change has been in the relationship between the community and the clinic ; this change has brought in its train certain problems which may be met with elsewhere in due course.

At first, only the seriously maladjusted or neurotic children were referred to us, whereas to-day, in addition, we get a large number of less severe behaviour problems and other cases.

As an administrator I have sought to protect the clinic team from this heterogeneous crowd.

It is possible in most cases, from a brief history of the case, to divide the children into three groups and allocate them for appropriate action.

1. *Disturbed, maladjusted or neurotic children.*

These require full-team help and are legitimate Child Guidance Clinic cases.

2. *Children reacting (possibly normally) but also exasperatingly to their environment, approaching the "beyond control" category.*

A full history by a psychiatric social worker should reveal these, and an approach to the mother, and visits to the home may be all that is necessary. The psychiatric social worker will be working in consultation with the psychiatrist, with whom, for such cases, she will have a weekly individual session.

Patients may, if necessary, be referred for full treatment by the psychiatrist.

3. *Children failing in school, generally or in specific ways, with or without disturbing conduct patterns.*

> Such are essentially educational and not psychiatric or sociological problems. They should be seen by an educational psychologist.

When the individual problem has been elucidated and the special needs of the child are understood, suitable provision can or should, under this statute, be made for such children.

In my view, unless such means of accurately determining the needs of a child who is failing at school are provided, a child guidance service which has gained the confidence of its public will be forced to deal with a large number of such children to the detriment of its own proper work. This is a waste of skilled and scarce psychiatric time, and a waste of public money.

Administratively, this provision can be made by the Local Education Authorities in a number of ways. I hold no brief for any particular one, but in my view, as a matter of practical, clinical importance, any scheme should ensure that the educational psychologist works both in the schools, doing purely educational assessments, and in the Child Guidance Clinic, as a normal member of the team. In Hertfordshire this has always been the case, the psychologist being employed by the Clinic authority (National Health Service), but by arrangement spending days in the schools and working there independently. I am concerned at proposals that this school work may be curtailed or discontinued.

I believe that failure in school, particularly failure to read fluently—the cause of which is not always readily understood—is not infrequently a factor in causing serious maladjustment.

Recurring failure conditions children against school and so against authority. It is a door to delinquency and, although it is true that other influences may be sufficient to prevent a child from passing through this door, it is far better that they should never be brought there.

Dr. W. Mary Burbury (*Medical Director, City of Manchester Education Committee Child Guidance Clinic*). As Director of the City of Manchester Child Guidance Clinic, a psychiatrist on the staff of the Children's Hospital, and a member of the Psychiatric Sub-Committee formed by the Manchester Regional Board, I have, as it were, a foot in various camps. Further, the Manchester City Child Guidance Clinic extends its work far beyond the scope of Manchester City and covers many of the surrounding districts in the Counties of Cheshire and Lancashire.

I have now been twelve years in Manchester and I can truly say that the Local Authority have given us a very good deal. We have a complete staff of fully qualified people ; our quarters are good ; and no objection is ever raised to providing us with the material for which we ask.

The qualification for attendance at the Manchester Child Guidance Clinic within the City of Manchester is that you should live in the City of Manchester. It does not matter how you come ; you can come from the Local Authority, from the School, from a private doctor—there is no limitation.

So far, so good. We have been very satisfied and we have been very happy, but there *are* difficulties. It seems, for example, to be tacitly assumed that if you are under a Local Education Authority you have absolutely free access to their schools, and in Manchester we have found that not to be the case ; we can go into the schools, yes ; but, except where we go in about our own cases, we are not very welcome—I refer not to the schools themselves, but to the Authority behind the schools. We are trying, gradually, to build up a different attitude about that.

Also, we are a teaching Clinic now, and the attitude of the Authority to teaching work is far from satisfactory. They accept it on sufferance, if they are persuaded that, in fact, they get a lot of work done for nothing. The other point about the teaching position is that, because we are a Local Authority Clinic, we are very much cut off from the rest of the medical teaching work. In the University of Manchester the Professor of Psychiatry and the Professor of Child Health are very anxious to have our co-operation, but it is a friendly relationship and carries no official recognition.

Then—and this is something that people in London probably find it extraordinarily difficult to realize—the work in the Local Authority set-up is very much cut off from the rest of the medical personnel and particularly from the rest of the psychiatric personnel in the area. Since there has been so much meeting together since the Health Act, I have begun to realize how little I know of my psychiatric colleagues in the area.

And lastly, one of the drawbacks—a very important one in a Clinic of this considerable size—is that when I say to the Local Authority, " We should like to do this or that in the way of research ", the answer I invariably get is, " There is not any time for research as long as your waiting lists are as they stand at present." That seems to me one of the most deplorable things in this attitude of the Local Authority.

Now, though I must be brief, I want to turn to the other side of the picture—the Clinic at the Manchester Children's Hospital. It is a one-man Clinic. I run it entirely myself, except when I get any kind of voluntary help, or when the extremely over-worked Almoner sends me a report on a case that has to be seen. I have to do my own testing. I have to spend a great deal of time with the parents of the children, because there is no psychiatric social worker to take the history for me. So there it is—no staff. If there is anything worse than that, it is the premises. The premises are truly awful, ordinary clinic rooms with tiled floors and walls and medical apparatus all over the place. The redeeming feature of this appalling situation is that it gives

me the opportunity to come into contact with all the specialists in children's work on the physical side in the City ; it gives me the opportunity of contact with those cases which are on the borderline between the physical and the psychological ; and, as I have realized increasingly recently, since the Health Act came into full operation, since the hospitals adopted the plan of appointments and sending cards to the doctors to fill in for appointments, it has given me an insight into the needs and demands of the general practitioner which I never had before. The cards came into operation in this hospital at the beginning of June. At the end of April the waiting list for that Clinic was three weeks. It is now nine months, and it is quite impossible to keep pace with it. I spent some time, a day or two ago, looking through the list because I felt sure that some of the doctors must be finding a quick way round the mental deficiency problem, but I only eliminated about ten and sent them back as educationally sub-normal or uneducable and needing to be referred to the Local Authority for testing on those grounds.

I think perhaps this illustration of having a foot in both camps does emphasize the enormous importance of what the chairman called " Combined Operations ". In the first place there is a shocking waste. I find from time to time that cases have been referred to me which either have been seen already in other Clinics in the area or which I have already seen in my own Clinic. Secondly, there is a tendency to play off one against the other ; and if we have something combined, while it may be perfectly true that one kind of case is more suited to one kind of doctor, it will be a matter of choice in co-operation and not, as it sometimes appears to be, in opposition. Thirdly, if we can have a combined kind of work, it *will* mean a saving of staff.

I hope you agree that some co-operation is necessary, perhaps on Dr. Kimber's lines, perhaps—as I hope in my own area—by setting up a Joint Committee of the heads of the Local Authorities and the Regional Board for the organization of Child Guidance work throughout the Region.

GROUP DISCUSSIONS

For lack of space, the findings of the eleven groups cannot be printed in full. The point, however, which stands out above all others is the concern felt at the proposal of dichotomy in the Service, as embodied in Circular 179. One group, unanimous in condemnation of the division, suggested that " the best administrative compromise was to have the Clinic under dual or multiple control of a Local Committee where Health, Education, and the Regional Hospital Boards were represented ; and, on balance, it was felt that the smaller the area to administer the needs of a particular Clinic, the better ". Another group emphasized the need for finding a way of working harmoniously under the two Authorities, because the Service extended into both fields.

There was considerable resistance to the new terminology (Child Guidance Centre and Child Psychiatric Clinic) and it was clear that the familiar term " Child Guidance Clinic " would be long in vogue.

Other points put forward were :

1. There was a fear of recommendations of the Centre being ignored and intake being restricted to educational problem cases in Centres run purely by the Local Education Authority. It was felt that, as a general rule, applications should not be sieved by School Medical Officers, nor should initial referrals have to be made to them or to their Departments.
2. Difficulties were often encountered in connection with referrals of children of pre-school age, children who had left school and children who attended private schools.
3. The new Health Act had made little difference, so far, to the way in which Centres were run. They showed great diversity of method. The quality of local relationships was more important than the " set-up ", and the onus would continue to rest on the Clinic team, whatever the final form of the Service.
4. Working under Regional Hospital Boards would involve more difficulty in getting into the schools than working under Local Education Authorities.
5. There was wide-spread awareness of the dangers of specializing solely on work with children.
6. It should be the responsibility of the educational psychologist, with his particular knowledge, to ascertain educational sub-normality. The disposal of the educationally sub-normal should not be made without a full-team investigation.

Dr. Jacobs (*St. George's Hospital*) and **Dr. Creak** (*Great Ormond Street Hospital*) spoke by invitation of the Chairman at the end of the morning session.

AFTERNOON SESSION

SUGGESTIONS FOR FUTURE POLICY

Dr. R. F. Barbour

Medical Director, Bristol Child Guidance Clinic ; Vice-Chairman Clinical Services Committee, National Association for Mental Health

In the past we have been—and I gather from this morning's Conference we still are—what I might term a professional anomaly. We apparently were in the past, and we still are, an administrative nuisance. One Director of education said, in a rather unguarded moment, " You make problems." With a blush, he quickly amended that to, " You discover them for us." I think that the first phrase was more from his heart, and I feel that at present there is a risk that we may find ourselves, not consciously but possibly subconsciously, tending to serve the administrator rather than help the child. While we are on this subject we might—most of us—be thinking of means of improving our techniques in our relationships with officials.

This leads to my second point the importance of preserving this principle of the team. The basic assumption of child guidance is that behaviour problems in childhood arise from a variety of causes and as a result will demand a variety of techniques for their solution. Most of us say perfectly frankly that we are in favour of a team. On the other hand there are people who feel that abbreviated teams have a really useful function to perform. We all know that at the present moment Clinics have to work short-staffed, and obviously we may have to accept this as—but only as—an emergency measure, like rationing. Nevertheless I should like to see those Clinics which have not the full team, keeping the fact in the eyes of the public, listing their establishment at the top of their letter-paper : psychiatrist, with the name opposite ; psychologist, with the name opposite ; psychiatric social worker, with the name opposite ; and against any of those positions that they are unable to fill for the time being, the word " vacant " should be put. It is all too easy for our administrators to become accustomed to our working short-staffed. Some of us have had to work short staffed for two or three years and possibly longer. They may even get the idea that a psychiatric social worker is not essential, or even that a psychiatrist is something of a luxury and that a School Medical Officer really can do the work just as well.

Let me repeat, we are an anomaly, and I think we have got to face that fact and take the responsibility for our policy based on that fact. We do not fit nicely into any of the administrative compartments. We serve two Local Authorities, the Education Authority and the Health Authority ; we serve the Regional Hospital Board, and in certain cases, in University towns, we serve the Hospital Board of Governors. In theory, this should present no difficulties, as the " joint user " principle is stressed time and time again in the National Health Act, but in practice it tends to be cumbersome. The question, I think, is whether we are capable, whether we are good enough psychologists, good enough psychiatrists, good enough psychiatric social workers, to handle these people, whether we can get all these authorities to come to an agreement. It is a hard task, but I am certain it is no harder than our work with a large number of parents, or even teachers or general practitioners, and I think that at times we have tended to fold our hands and, so to speak, cross them off the treatment list.

If, however, we do succeed, there is practically nothing that cannot be done under the National Health Act or under the Education Act. Almost every clause starts with the phrase " has the power to . . . " but it is permissive and not compulsory.

On the matters of referrals, around which there was considerable discussion earlier to-day, I cannot resist saying that I should like to see open referrals made the general rule that it is in Bristol—open referrals by parents, by teachers, by School Medical Officers, by social agencies. I do not see why certain parents should have to tell other Authorities or someone who may not be understanding, before they can arrange for a child to have treatment.

I am looking forward to the developments of the next fifteen years in Child Guidance. The last twenty years have seen many advances, chiefly, however, on the educational side, and I hope that we are going to see equal progress on what I would call the medical side. The broad interpretation of " maladjustment " makes it possible for us to finance the treatment of the maladjusted child fairly easily ; and I think it is time, as Dr. Creak was saying this morning, that we should now woo the paediatrician as enthusiastically, and let us hope as successfully, as we have courted the teacher. Much research is needed on the whole question of the development of the central nervous system and the influence of the endocrine glands on behaviour. I think that in about ten years' time, provided we can get adequate staff and adequate interpreters, the electro-encephalogram will probably be found as part of the routine set-up of every Child Guidance

Clinic. Here again let me stress that it is team-work. In Bristol the psychologists are asking for certain children to have E.E.G.s. Why? Because they are beginning to see that certain types of dysrhythmics, when they reproduce the Terman-Merrill designs, tend to make specific errors. It is team work again.

It is only too difficult, as you know, to obtain foster homes, and our schools for handicapped children are woefully inadequate as far as maladjustment is concerned. It is my opinion that other forms of homes are necessary for residential treatment. Staffing may be difficult and financing may be difficult, but at any rate under the National Health Act they have got as far as planning them and I think the staff and the finance will be forthcoming.

Let us look for a moment at the composition of the team, and the question of standards of training. We do not know how long it is going to be possible for the N.A.M.H. to make arrangements for training Fellows. Are we going to say that any person who has the Diploma of Psychological Medicine is automatically capable of running a Child Guidance Clinic? One of the big differences, as you know is that at the present moment there is no *selection* for the Diploma of Psychological Medicine. It is a matter of finding the time and the money. On the other hand, for the Fellowships, every potential Fellow was seen by psychiatrists and quite a fair percentage were in fact rejected. Can we accept this position in the future as satisfactory? Also, there is a danger in one or two places of the psychiatrists themselves becoming administrators, or at best diagnosticians, rather than therapists, the real therapy being left to play-therapists, psychologists and other selected people.

Psychologists seem to be in better supply than either of the other two members of the team and this often means that it falls to them to double for the other members, regardless of whether this is the best use of their ability and training.

My biggest problem, as a Clinic Director, is the shortage of psychiatric social workers. Pre-war, as some of you may remember, the ratio was one psychiatric social worker to a half-psychiatrist and a half-psychologist. The ratio in many clinics now is almost the reverse, and this has meant rather serious changes. Outside contacts have had to be cut to a minimum. It has severely limited the time the psychiatric worker can spend in meeting and discussing Child Guidance problems with other social agencies, and I am thinking, in particular, of people like Children's Officers, Probation Officers, and the like. Do not forget that Child Guidance started originally and chiefly as a community service, and although treatment of the individual is important, there are certain problems which are best tackled at the social level. In some Clinics the home visit, which used to be more or less routine, is now regarded almost as a luxury.

It seems to me that two sections of our work which will present easier organization under the National Health Act are: (1) the whole question of treatment of parents; and (2)—a big problem at present—treatment for the boy of about fifteen to nineteen, who has left school: treatment for such cases should be possible in a Child Guidance Clinic, but at present, in general, that need is not met.

My final point is that we must make a drive on this whole question of training, and if we believe that the team approach is not only desirable but practically essential for us, it is very important that the teaching staffs of these various disciplines should work in close co-operation.

DISCUSSION

Professor D. R. McCalman (*Department of Psychiatry, University of Leeds*). There have been times when I have wondered whether we were tending to lose sight of the real object of Child Guidance—the problem child. Too many of us spend too much time on administration and organization, but this afternoon Dr. Barbour has brought us back to our proper place in the clinical field.

Although there has been a great increase in the number of clinics we must, as Dr. Barbour has indicated, make every attempt to increase our potential for training. In many areas there is a need and a demand for Child Guidance which cannot be fulfilled because adequately trained staff cannot be obtained. Such a situation always increases the danger of untrained personnel being employed by Authorities whose enthusiasm outstrips their good sense. We know how many Authorities have for years been eager to employ psychiatric social workers and who, despairing of ever attracting a fully-trained worker, are now contemplating appointing the next best thing. The same is true of psychiatrists. We should resist the assumption made by some authorities that a psychiatrist is qualified to work in a Child Guidance Clinic, as a consultant, merely because he has obtained a D.P.M. There is, therefore, a great need for the number of training centres to be increased. So long as the standard is maintained, there is no reason why a number of Regions should not undertake, in conjunction with the appropriate University Departments, the training of psychiatrists, psychologists and psychiatric social workers, until the present need is met.

The second question I should like to raise, concerns the use which is being made of existing clinics. The orthodox Child Guidance team is an expensive instrument which must be used to the best advantage. I have always felt that it should be used in a consultant capacity, and called in to help in the diagnosis and treatment of unusual and difficult cases. In the process of dealing with such cases the clinic should, indirectly, educate a number of persons and agencies in the community, and they, in turn, should be better able to deal with less pathological cases along the same lines. Methods should

gradually be evolved whereby the clinic could safely act as a consultant agency to probation officers, teachers, doctors, health visitors, parents, etc., who might in time be regarded as the general practitioners in the field of mental hygiene. This, in turn, would free the clinic to tackle the very type of caste for which it was originally designed. I was glad to hear from Dr. Kimber that developments along these lines are already taking place.

Thirdly, are we, as a Child Guidance movement, making the determined effort which is necessary to tackle some of the more pressing problems in the broader aspects of mental hygiene. Often, when investigating a case of delinquency, we find environmental conditions so conducive to asocial behaviour that we wonder whether it is worth while instituting individual treatment. Do we then move outside the bounds of medicine and education in an attempt to modify these wider social and cultural problems ? Any such attempt pre-supposes that we know how to educate and whom to educate in the general principles of mental hygiene. It is not sufficient for us to provide the community with a method of dealing with children after they begin to show psychopathological symptoms; we must also try to prevent such maladjustments by encouraging positively beneficial influences upon early development.

Have we learned from our study of pathological conditions enough about mental hygiene to be able to carry out this type of educational propaganda ? How many statistically evaluated facts do we know about child development ? What figures have our clinics produced ? If it can be shown that 34 per cent of mothers in an unselected group of delinquents went out to full-time work, and 8 per cent went out to do part-time work, that statement is more convincing to a lay person than any story, no matter how pathetic, about one delinquent whose mother went out to work.

Again, is there anyone following up the earliest cases to attend Child Guidance Clinics in this country ? There must now be men and women in their twenties or thirties, perhaps parents themselves, and, if so, how are their children faring ?

Only facts of this type can justify the value of our methods and our claims that Child Guidance provides a method whereby problem children can be successfully treated.

Dr. Mary Capes (*Medical Director, Southampton Child Guidance Clinic*). I, too, feel that I must refer to the rather wide ignorance among school teachers, for example, and on Local Authority Committees, as to what Child Guidance sets out to do ; Regional Hospital Boards are also ignorant. For example, recently we found that it had been thought a nice idea to switch us from the excellent premises of the Local Authority, into the Regional Hospital building where there literally was not a room for us to work in. Nobody had considered that as a practical detail, and the Regional Hospital Board did not appear to realize that there was an educational problem at all or how much work was being done in the schools.

In my own area, the Education Officer and I are the best of friends, but he makes it clear quite often that he would like the Clinic to be run from an educational and not from a medical standpoint.

We have a system, under the Local Authority, however, which seems to be working happily, and by which the educational psychologist works half-time in the Clinic, and half-time in the schools, apart from the Clinic. During the past year, in her work in the schools she has tested and interviewed 349 children, and from that number she has only referred 15 to the Clinic, that is 4·3 per cent. Children may be referred by anyone and the number seen at the Clinic itself last year was 221. It is my policy to ask the psychiatric social worker and the educational psychologist to see them first. (I do not work full-time ; they do.) Of the 221 who have been referred, 200 have been sent on to me, which means that about 90 per cent. of the Clinic children are psychiatric problems.

I feel that if the Education Authorities could realize what scope an educational psychologist has in the schools, when in the team set-up, they would feel less anxious altogether and they would not say, as they have in the past, " Keep out the psychiatrist ".

This leads me on to mention that we must beware of our own ignorance as well as of the ignorance of people who cannot know altogether what we are attempting, and I feel that we must know what training a member of the team should have had. I speak as one who has suffered as an untrained child psychiatrist ; I entirely endorse what was said of those who have taken the Diploma in Psychological Medicine and studied adult psychiatry, but not child psychiatry. I am apalled by what I have done myself, starting work with inadequate training, and I think it is up to us all to see that we are trained to the extent that the National Association has set down.

I would like to add this controversial note : that we have to remember that we probably all experience a struggle in the urge for power. The Ministry of Health and the Ministry of Education may be happy together : I do not know ; but in the Local Authorities very often one meets, in the Counties or the Boroughs, struggles between the educational side and the medical side, and in the Clinics, often, we also should take ourselves off to a quiet spot and consider whether we, as psychiatrists, are perhaps abusing the power that we have ; perhaps our psychologist friends should also do the same if they are running the Clinic. In fact I think that the happiest Clinic is probably one in which the psychiatrist deals with the psychiatric aspects, the educational psychologist with the educational aspects, and the psychiatric social worker, besides all the other work she does, runs the Clinic !

GROUP DISCUSSIONS

There was, unfortunately, only time for seven of the eleven groups to report their findings. Briefly the main points arising were :

1. The urgent need for facilities for training Child Guidance Staff, and the responsibility of the Universities in this connection.
2. Some of the training must take place in the Clinics where the practical problems arise. If, however, a Clinic has a teaching function, the responsibility for teaching must be recognized in the form of extra staff or extra time.
3. The status of the psychiatric social worker must be improved.
4. Disposal facilities caused considerable anxiety.
5. Various suggestions were made for avoiding the splitting of the Service, for example, that the Local Education Authority should employ the lay members and provide the premises, while the Regional Hospital Board supplied the psychiatrist. Another group suggested Joint Committees at all levels.
6. The Service should concern itself with validating and justifying its work and selecting its cases, while avoiding " over-selling ".
7. In the present state of affairs, waiting lists seemed irreducible.
8. More guidance from the Clinics was needed in regard to schools for the maladjusted.
9. Inter-Clinic Conferences were regarded as very valuable for the sifting and exchanging of views.

SUMMING UP

Miss Lucy Fildes, Ph.D. (*Chief Psychologist, London Child Guidance Training Centre*). Perhaps a useful way of summing up would be for me to stress one or two points that have developed.

This morning the problem, as it appears at present, was put before us very precisely. It is clear that Child Guidance is on the map. I have been working in it since the start, and it is very satisfactory to see it on the map. Clearly, however, with the arrival of the National Health Act, difficulties in administration and organization must arise, and those difficulties were clearly presented to us.

The Education Authority is ultimately responsible for child guidance, as stated in the Education Act of 1944. If that Authority finds that the work is not being done by anyone else, it is obliged to do something about it. In other words, it cannot shelve its financial responsibility.

The Health Authority is free to develop any medical treatment which it considers desirable, but it is under no compulsion to develop it in the form of Child Guidance as we know it. It can develop Child Guidance as a preventive service ; it can develop it as a therapeutic service, and quite certainly is doing so ; but the final legal responsibility rests with the Education Authority.

It was very interesting to hear from later speakers this morning that in general, Clinics are functioning in much the same way as they were before the Health Act. All the same, we must face the fact that problems will make themselves felt when the Regional Hospital Boards have had time fully to familiarize themselves with the nature and intricacies of the Service which has been presented to them. Will they, or will they not, advocate team service ? It is up to us to decide what we think of team-work and whether we are going to press for it. If we consider that team work is essential, we should have some clear idea of the responsibilities of the different members of the team in relation to the whole general Service, both preventive and therapeutic.

What the nature of that Service should be has been revealed in the discussions : the idea, for instance, that the psychologist should serve the schools as well as the Clinic : that the psychiatrist should in no sense become merely a diagnostician in a Child Guidance Centre—and I notice that nobody here has used that word, except from the platform : that the danger of this dichotomy between an education service and a service under the Health Authority must in some way be met, and that we should have a definite general policy as to the best way of meeting what is undoubtedly likely to become an increasing danger to Child Guidance work as we know it.

We have heard much about what is essential for the general future of Child Guidance : the need for extension of training ; for variety of experience ; for co-operation ; for research ; and the importance of making known the real function of Child Guidance work, without " over-selling " the Service. If our services are—and can be shown to be—of value, the question of finance will cease to haunt us. It will not be as easy to show the results of Child Guidance, as it is to prove the effectiveness of much physical treatment, but it will be incumbent on us to present our facts.

On the question of general policy, can we make up our minds, for instance, that it would be the best policy for Child Guidance services to be run by the Authority which is obliged to run them, if nobody else will, while co-operating with the Health Authority by having psychiatrists seconded from that Authority ? If so, let us say so.

A suggestion was made which carried this intention of avoiding the dichotomy yet further : the establishment of Joint Committees responsible for Child Guidance. I assure you it is not easy to be governed by a Committee which has under its aegis the general hospital, the foot clinic, the Child

Guidance Service, and a variety of other departments. But surely it would be much more helpful to try to work towards prevention of this dichotomy on the lines of encouraging co-operation between the various Authorities which are capable of arranging the finance and administering the Service.

All I can say, therefore, is that from this meeting some expression of opinion should be given as to what we consider are the essential things we want. Do we want to continue the team work ? Do we stress this question of the need for training in co-operation, at any rate, with Universities ? Do we deplore the possibility of squabbling due to dichotomy of control, through different Authorities setting up opposing Clinics ? Indications of mental ill health on the part of the people controlling the whole matter cannot produce mental health.

The Chairman then asked for a show of hands, as follows : Those who are against the idea of going forward on the basis of the present team.

(*No hands raised.*)

Those who are against the idea of further training in conjunction with the Universities.

(*No hands raised.*)

Those who are against the idea of Joint Committees at all levels.

(*One.*)

The **Chairman** thanked the members for their attendance, saying that next year it was hoped to hold another Conference on the much more happy topic of " The Child ".

SOME PERSONAL SECOND THOUGHTS ON THE INTER-CLINIC CONFERENCE

BY ALAN MABERLY, M.B., B.Ch., M.R.C.S., L.R.C.P.

The ouststanding impression that remains after the Inter-Clinic Conference is that of the remarkable degree of unanimity of opinion on all issues of real importance, and in particular on the value of full team work, and on the dangers of any administrative set-up which would split the functions of a team, or of any of its members.

It may not have been realized by all those who attended how much encouragement and support is given by these conferences to those at headquarters of the National Association for Mental Health, in their endeavours to maintain the standards in Child Guidance work.

Group discussion, even in the short time available, was singularly successful in presenting and summarizing the views of so large a meeting, and it seems probable that no other method could have indicated so clearly the sum total of individual viewpoints. This, as with most other aspects of the meeting, would have failed in its object had it not been for the efficiency of organization by the office staff, and we all owe a debt of gratitude to those who put in so much work behind the scenes.

While we would all agree with Professor McCalman that our main concern is the problem child, we are not all of us as fortunate as he is, in the fastness of his University, to be able to control the administrative set-up in which he works. Unless we remain alert, we may find ourselves faced with circumstances which make difficult or impossible the implementation of the recommendations in relation to the patients we see. It may seem fairly innocuous when it is suggested that " General Administrative Responsibility " should lie with the School Medical Officer or with the Divisional Director of Education, but very real difficulties will quickly arise unless the limitations of this administrative responsibility, together with the boundaries of " clinical direction " in the hands of the team, are very clearly defined. Only recently, one team with which I am associated was faced with the demand that Form 1 H.P. should be completed every time Form 2 H.P. was used to recommend provision of special education. This was designed to ensure that if, when a vacancy arose at a suitable school, there should be no delay in over-riding any objections the parents might then raise. This was notwithstanding the relevant clauses in the Education Act prescribing that the form should not be used as a routine matter, and ignoring entirely the inappropriate nature of such a regulation in connection with mal-adjusted children. On the other hand, it is both wise and right that clinicians should be relieved of the responsibility for dealing with window cleaners and gas accounts.

Those of us who have been long in Child Guidance work are familiar with the irritation that the team set-up has caused to many administrators because it has not fallen neatly into any single departmental category. The only new factor that has arisen is that the rivalry between Directors of Education and Medical Officers of Health has now been extended to ministerial level. One hopes that, at this level, integration will prove an easier and more practicable proposition.

In Dr. Alexander's regrettable but unavoidable absence owing to an engagement overseas, his one-man campaign for the introduction of the Scottish form of Child Guidance set-up to England (to which he alludes as the " British pattern which had its beginnings in the work undertaken at Glasgow under Dr. William Boyd ") received perhaps less attention than it deserved. Members of the Conference who are not readers of *Education* would be well advised to look up the issues of October 28th, 1948, January 14th, 1949 and November 11th, 1949. It will be noted that Dr. Alexander makes no reference to the earlier work of Professor Sir Cyril Burt, nor to that of Dr. Hamilton Pearson or other pioneers in this country.

We should all heed the warning against over-selling our speciality, although at this time the danger might seem to be greater in the field of adult psychiatry in general than in Child Guidance. Furthermore, it is the quality of the salesmanship rather than its quantity which requires attention. We can all of us be modest in our claims, without losing confidence in our methods. We can avoid obscurity of language, but need be none too ready to produce the figures that are often demanded of us, because much of the value of Child Guidance work cannot be assessed in numerical terms at all, any more than can that of the School Health Service, which is predominantly preventive. With the human material with which we deal, it is only rarely possible to produce controlled experiments, and these should be conducted by research workers rather than clinicians. Even if the claim of the Scottish workers that they cure 100 per cent. were true, there is no means of proving that these cases would not have been cured 100 per cent. without any treatment at all. We should not play into the hands of those who regard human personality as capable of being weighed, counted and measured by accepting their premises without question.

HEADLEY BROTHERS, 109 KINGSWAY, LONDON, W.C.2; AND ASHFORD, KENT